S. HRG. 101-549

INDIAN VETERANS

HEARING

BEFORE THE

SELECT COMMITTEE ON INDIAN AFFAIRS
UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

ON

OVERSIGHT HEARING ON INDIAN VETERANS

NOVEMBER 14, 1989
WASHINGTON, DC

U.S. GOVERNMENT PRINTING OFFICE
26-623 WASHINGTON : 1990

For sale by the Superintendent of Documents, Congressional Sales Office
U.S. Government Printing Office, Washington, DC 20402

S411-16.

SELECT COMMITTEE ON INDIAN AFFAIRS

DANIEL K. INOUYE, Hawaii, *Chairman*
JOHN McCAIN, Arizona, *Vice Chairman*

DENNIS DeCONCINI, Arizona
QUENTIN N. BURDICK, North Dakota
THOMAS A. DASCHLE, South Dakota
KENT CONRAD, North Dakota
HARRY REID, Nevada

FRANK H. MURKOWSKI, Alaska
THAD COCHRAN, Mississippi
SLADE GORTON, Washington

ALAN R. PARKER, *Staff Director*
PATRICIA M. ZELL, *Chief Counsel*
ERIC EBERHARD, *Minority Staff Director/Counsel*

CONTENTS

Statements: Page

Apuna, Dr. Samuel, member, Native American Veterans Affairs Advisory Committee, Mililani, HI 30
Chappabitty, Dr. Edwin, chief of medical staff, Lawton Indian Hospital, representing the Comanche Tribe, Lawton, OK 5
Collins, Tom, Assistant Secretary, Veterans Employment and Training, Department of Labor, Washington, DC 14
Field, Raymond, chairman, Native American Veterans Affairs Advisory Committee, Silver Spring, MD 27
Haney, Jerry, principal chief, Seminole Tribe of Oklahoma and National Commander of the Vietnam Era Veterans Intertribal Association, Shawnee, OK 11
Inouye, Hon. Daniel K., U.S. Senator from Hawaii, chairman, Select Committee on Indian Affairs 1
McCain, Hon. John, U.S. Senator from Arizona, vice chairman, Select Committee on Indian Affairs 2
Morris, Raymond D., executive director, Office of Navajo Veterans Affairs, Window Rock, AZ 3
Permison, Dr. Stephen, director of patient care policy, Indian Health Service, Rockville, MD 19
Twist, Ted, former veterans service office, Division of Veterans Affairs, South Dakota 8
Vogel, R.J., Chief Benefits Director, Veterans Benefits Administration, Department of Veterans Affairs, Washington, DC 22

APPENDIX

Prepared statements:

Apuna, Dr. Samuel (with questions and answers) 221
Billy, Irving, interim vice chairman, Navajo Tribal Council 40
Chappabitty, Dr. Edwin, chief of medical staff, Lawton Indian Hospital, representing the Comanche Tribe, Lawton, OK 43
Collins, Tom 180
Field, Raymond 213
Haney, Jerry (with attachments) 47
McCain, Hon. John, U.S. Senator from Arizona, vice chairman, Select Committee on Indian Affairs 35
Morris, Raymond D 40
Murkowski, Hon. Frank H., U.S. Senator from Alaska 38
Permison, Dr. Stephen 186
Shaw, David Ortega, Department of Veterans Affairs Advisory Committee on Native American Veterans 213
Vogel, R.J. (with attachments) 191

Additional material submitted for the record:

Eluska, Sharon, letter 236

INDIAN VETERANS

TUESDAY, NOVEMBER 14, 1989

U.S. SENATE,
SELECT COMMITTEE ON INDIAN AFFAIRS,
Washington, DC.

The Committee met, pursuant to other business, at 9:30 a.m., in room 485, Russell Senate Office Building, Hon. Daniel K. Inouye (chairman of the committee) presiding.

Present: Senators Inouye, McCain, Daschle, Murkowski, and Gorton.

STATEMENT OF HON. DANIEL K. INOUYE, U.S. SENATOR FROM HAWAII, CHAIRMAN, SELECT COMMITTEE ON INDIAN AFFAIRS

The CHAIRMAN. Good morning, and welcome to this hearing of the Select Committee on Indian Affairs on native American veterans.

When America honors those who have fought and died in her wars, unfortunately a long list of courageous volunteers are usually forgotten. Ever since colonial times, native American Indians have enlisted to fight the wars of the United States. Even in pre-revolutionary wars, Indians fought at the side of the American colonists.

The famous Oneida Chief Shenandoah fought with colonists in the Battle of Oriskany, which was a very important battle, because it stopped the British advance toward the Mohawk Valley of New York. And most significantly, during the terrible winter of 1777-78 when our first President—who was then a General—George Washington, and his troops came close to starvation and extinction in Valley Forge, Chief Shenandoah ordered several hundred bushels of corn delivered—on foot--to that sad valley, thereby saving our troops.

Native American Indians have participated in the war of 1812, they fought courageously in the Civil War on both sides, and the Mexican and Spanish American wars and they have served in very large numbers during the two World Wars, the Korean Conflict and the Vietnam War.

In World War II, when communications between the Allies were continuously intercepted by our enemies and the need for a code which could not be broken became key to our survival and success—it is now legendary—but it was the Navajo Code Talkers and the Comanche Code Talkers, whose native languages provided a means of communication that eluded the most expert of code breakers. Allied intelligence officers tell us that this code was the only code that was not broken during World War II.

Little is known about one of America's greatest heros, Ira Hayes. He was a Pima Indian who served in the Marine Corps during the Korean Conflict. He is depicted in the Iwo Jima Memorial as one of the brave men who planted the American flag. Here again, unfortunately, his bravery was soon forgotten, and he died a broken man and a victim of alcoholism.

More recently, between 1964 and 1975, over 82,000 American Indians have served in this country's armed forces. Close to 90 percent of this number volunteered for service and over half served in combat. These brave men and women represent the highest percentage of any ethnic group in the United States to serve our country.

The 1980 census data indicates that even though the total Indian population comprises only one-tenth of 1 percent of the United States population, there are six times as many Native American veterans, representing .6 percent of all veterans in civilian life.

Even though a great number of Native American veterans have served this country with incomparable bravery and valor, the recognition and level of services which have been provided to Indian veterans remains largely undocumented. It would appear that in our efforts to mainstream our country's veterans, the needs of America's Indian veterans have been forgotten.

This morning's hearing is designed to enable the Senate Select Committee on Indian Affairs to examine the problems, assess the effectiveness of services and explore the solutions necessary to fulfill the needs of Indian and Native American veterans.

We have invited the testimony of a number of Indian veterans who represent tribes and veterans support organizations, as well as the views of the Federal agencies that are most involved in addressing the needs of veterans. We respectfully request that the representatives of the Department of Veterans Affairs, the Department of Labor and the Indian Health Service fully examine the testimony which will be presented this morning.

As a veteran, I am honored to recognize those who have served this country so well. Be sure that your recommendations and those of other Native Americans across this land will be fully considered as we work closely with the Veterans Affairs Committee to develop legislation responsive to your needs.

Our first panel of witnesses will include Mr. Raymond Morris of the Navajo nation; Dr. Edwin Chappabitty of the Comanche Tribe; and Mr. Chuck Richards of the Oglala Sioux Tribe.

Before we proceed, I would like to call on one of this Nation's truly great heros, one who served and suffered for all of us, and I would like to at this moment recognize this great man—I have not had the opportunity to do so in the past—I wish to tell my good friend John McCain how much I appreciate his service to us.

STATEMENT OF HON. JOHN McCAIN, U.S. SENATOR FROM ARIZONA, VICE CHAIRMAN, SELECT COMMITTEE ON INDIAN AFFAIRS

Senator McCAIN. Thank you very much, Mr. Chairman.

Thank you for your kind words and I commend you again for once again exercising outstanding leadership on this issue.

We both know that Indian and Native American peoples have demonstrated unparalleled devotion to our Nation in their service to the armed forces. On a per capita basis, no group of Americans has served more honorably.

Mr. Chairman, I would like to have my complete statement made a part of the record. I would just like to state that there are unique situations with regard to Native Americans and a lot of it has to do with geography, a lot of it has to do with accessibility, a lot of it has to do with access to information concerning veterans' programs and benefits.

I am pleased to have this hearing, so that we can perhaps improve dramatically the access and availability to veterans benefits amongst those Native Americans who have served. They deserve it.

Frankly, Mr. Chairman, in my view, from everything I have seen, from visits to reservations in my state and around the country, they are not receiving those benefits for a variety of reasons. I believe with a little bit of time we will be able to correct these difficulties.

Thank you, Mr. Chairman.

[Prepared statement of Senator McCain appears in appendix.]

The CHAIRMAN. I thank you very much.

Senator Murkowski has advised me that he would like to have his statement made part of the record. He regrets he will not be with us this morning. Without objection, his statement will be made a part of the record.

[Prepared statement of Senator Murkowski appears in appendix.]

The CHAIRMAN. I have been further advised that Mr. Chuck Richards is not able to be with us, but his views will be expressed by Mr. Ted Twist, the former Veterans Service Officer of the Division of Veterans Affairs for the State of South Dakota.

I now call upon Mr. Raymond D. Morris.

STATEMENT OF RAYMOND D. MORRIS, EXECUTIVE DIRECTOR, OFFICE OF NAVAJO VETERANS AFFAIRS, WINDOW ROCK, AZ

Mr. MORRIS. Thank you, Mr. Chairman and honorable Committee members. My name is Raymond D. Morris and I am the Executive Director of the Navajo Office of Veterans Affairs. On behalf of the Navajo Nation veterans I am grateful for this opportunity to appear and testify before you today.

Navajo veterans represent a special group of American citizens who have served in the United States and foreign wars and in peace time. Today, there are approximately 16,022 living Navajo veterans registered with our office who have answered the call of duty during World War I, World War II, Vietnam and the Korean Conflict and during peace time. Even today, Navajo men and women continued to serve honorably in the United States armed forces.

The code talkers which were mentioned used the Navajo language in a code form to enable the United States armed forces in the Pacific to communicate vital military information which resulted in a major military victory for the United States. Therefore, the United States and the Navajo Nation must not and cannot forget ever the Navajo code talkers of World War II.

Our Navajo veterans have not received the recognition they have rightfully earned. Moreover, our veterans have been forgotten and have not received earned benefits, despite the sacrifices they made for the United States of America.

I am a U.S. Navy veteran and like many of the other Navajo veterans, have relatives who have served in the whole experience of the armed forces of the United States and are now in need of veterans benefits and services. We are here today to call your attention to the many needs of our veterans and seek your support and consideration in making certain legislative changes providing funding for veterans benefits and programs.

The Office of Navajo Veterans Affairs has identified through applications received an urgent need for veterans housing assistance. Due to lack of opportunities on the reservation, lack of community infrastructure, insufficient Navajo leasehold interests offering loan security to lending institutions for home loans, Navajo veterans require housing assistance in the form of a grant.

To date, only Arizona has appropriated $900,000 as matching funds with the Navajo Nation. We have not received any moneys from New Mexico or Utah for housing assistance to our veterans. The State of Arizona requires 50/50 matching funds.

For Navajo veterans who have the net income criteria to meet the Veterans Administration Guaranty Home Loan program, banks and private lending institutions are reluctant to make loans to Navajo people residing on the reservation. This is because our trust land cannot be offered as a security to lending institutions.

Navajo veterans are unable to secure home mortgage loans under the existing Veterans Administration guaranteed home program.

Regarding educational benefits, our veterans have underutilized educational benefits for various reasons, one is because of a lack of educational institutions located near the reservations and veterans must provide the basic necessities for their families. Thus, continuing education becomes secondary due to the fact that many veterans are the primary wage earner for their families and extended families.

Navajo veterans require the acceptance of Native American healing practices by the U.S. Veterans Administration as an acceptable form of medical treatment. Traditional healing practices are often needed to treat our veterans who have suffered physical and mental injuries as a direct or indirect result of serving in the military. Acceptable and allowable traditional medical treatment under the Veterans Administration medical program is necessary.

The Navajo Nation needs funding throughout the Navajo Reservation for veterans cemeteries. Presently, we have only one large central veterans cemetery near Window Rock, which is now closed because there is no more space available to bury any more veterans.

In closing, I respectfully request the committee to recommend to Congress the introduction of legislation that would reflect the needs and concerns of Indian veterans. In addition, we request that a Navajo representative be elected to serve on the Veterans Administration Advisory Committee. Such representation is essential in addressing the concerns and needs directly affecting our veter-

ans and all other Native American veterans throughout this country.

Mr. Chairman, honorable committee members, I appreciate your time and attention. If you have any questions, I will be glad to answer them at this time.

[Prepared statements of Mr. Morris and Mr. Billy appear in appendix.]

The CHAIRMAN. Mr. Morris, I thank you very much. I have several questions I would like to submit to you, so that you and your organization can take some time in responding to them, because some are rather technical.

One is on housing, and the VA Home Loan Guaranty program. The other is whether you would desire to have the time extended for utilization of educational benefits that all veterans are entitled to. Third, we would like to learn something about counseling services provided to Native American veterans.

Finally, we would like to know more about the role of the Office of Navajo Veterans Affairs is presently playing to meet the special needs of Navajo veterans. So my staff will be submitting these questions to you. I hope you can respond to them and return them to my office in about three weeks.

I thank you very much.

Mr. MORRIS. Thank you, Mr. Chairman. I will report these in written form. I could answer them right now, but I will write it up.

The CHAIRMAN. Some are rather technical, so we want to make certain that the response is precise.

Mr. MORRIS. Thank you, Mr. Chairman.

The CHAIRMAN. Now I would like to call upon Dr. Edwin Chappabitty, Chief of Medical Service at Lawton Indian Hospital. He is here to represent the Comanche Tribe of Lawton, OK.

STATEMENT OF DR. EDWIN CHAPPABITTY, CHIEF OF MEDICAL STAFF, LAWTON INDIAN HOSPITAL, REPRESENTING THE COMANCHE TRIBE, LAWTON, OK

Dr. CHAPPABITTY. Thank you, Mr. Chairman. I am Commander Edwin Chappabitty, Jr., a Family Practice physician and Chief of Staff at the Lawton Indian Hospital in Southwest Oklahoma. I am a member of the Comanche Tribe and a Chiricahua Apache descendant.

As a Regular Army officer, I served on active duty from 1967 to 1972. In Vietnam I was an artillery forward observer in an armored calvary squadron and later an artillery liaison officer with a tank battalion of the U.S. 25th Infantry Division.

I graduated from the University of Colorado School of Medicine with the assistance of the G.I. bill. I purchased my home through the VA home loan program. I am on leave today from the Indian Health Service and represent the Comanche Tribal Chairman, Mr. Kenneth Saupitty.

Military service veterans occupy a place of respect and honor throughout Indian country. Traditional Native American celebrations and pow-wows begin and end with veteran songs, honoring all servicemen and women for their dedication, devotion and sacrifice. The American flag is proudly carried or raised at these events by

representatives of the veteran community. Should an Eagle feather inadvertently fall from a dancers' regalia, the dancing stops while a veteran is selected to recover and return it to its owner.

Traditional Native American veterans organizations and warrior societies abound through Indian country. Such organizations as the Navajo Code Talkers, the Comanche Indian Veterans Association, the Kiowa Blackleggings, and the Vietnam Era Veterans Inter-Tribal Association are but a few. War mother societies participate along with their veterans. Who is not touched by the sight of an aged war mother's tears as sings a veteran's song in honor of a son who was lost in battle decades ago. Her loss is acknowledged by special war mother songs.

For the past 6½ years, I have had the honor of providing direct medical care to the Native Americans of Southwest Oklahoma, which include many veterans and their families. In doing so, I have obtained a detailed medical and social history on each patient. The issue of veterans status arises as it may offer pa possible alternative to Indian Health Service care, as well as recognizing specific veteran's issues such as Agent Orange exposure, post traumatic stress syndrome or Prisoner of War status.

In the area of veterans educational benefits, I find most Native American Indian veterans do not fully use these benefits. Most veterans reflect junior enlisted grades, typically serving only one or two terms of enlistment. The veteran who completes baccalaureate level training are usually those who had some college work prior to enlistment. Many veterans elect to enter trade schools, typically finishing these in several months to a few years after training begins. The remaining periods of eligibility tend not to be used by these participants.

Many veterans are aware that there are expiration dates on educational benefits but commonly do not know the actual length of eligibility. Veterans typically return home, seek employment, marry and start families in the communities which they left due to strong family and community ties. Few veterans are receptive to relocating to other states for job opportunities.

In regard to housing issues, most veterans I know do not use the Veterans Administration Home Loan Program. When asked why, one veteran replied "When I got out the Army, I didn't have a job, so I didn't qualify for a VA loan. It didn't matter if the rate was low or if there was no down payment." Many veterans simply returned to their parents' home or rent homes nearby.

In the past decade, the emergence of Tribal Housing Authorities has provided an attractive alternative in finding adequate housing. Many veterans receive modern, low cost housing on Indian Trust land through these programs with monthly payments based upon income and family size. The veteran may also find tribal housing authorities more lenient to late or delinquent payments.

In the health field, I note many Native American veterans rely solely on the Indian Health Service. Indian Health Service and various tribal health authorities operative a comprehensive line of health stations, clinics and hospitals throughout Indian country.

Many veterans do not possess health insurance plans. Veteran Administration clinics and hospitals may be located far from Native American population centers.

A dietary employee in my hospital, a former prisoner of war who parachuted from a burning B-17 into Germany stated "I only went to the VA Hospital in Oklahoma City a few times. It was almost 90 miles one way and the lines were longer than here. I only got to see the doctor for a few minutes." He never went back. When pressed further, he stated "This is my hospital. I get all my care here, my family, too."

Recently a VA clinic opened in our city, but few eligible veterans seem to have even registered there. They often state that the paperwork was too much of a hassle.

In summary, there exists a need to identify and inform Native American veterans of deserved benefits. Cooperation between tribal authorities and U.S. government agencies should be encouraged. Within mission requirements, Indian Health Service and the Veterans Administration should cooperate in identifying and meeting specific Native American health issues.

Thank you, Mr. Chairman.

[Prepared statement of Dr. Chappabitty appears in appendix.]

The CHAIRMAN. Dr. Chappabitty, I presume you have treated many Indian veterans.

Dr. CHAPPABITTY. Yes, sir; I do so on a day-to-day basis.

The CHAIRMAN. Do you find that Indian veterans have unique problems, unique in the sense that non-Indian veterans do not have them?

Dr. CHAPPABITTY. Their problems mirror the basic problems of the population. I take care of a few people who have war-related trauma, who prefer to come to the Indian Health Service for their care. I take care of one family with post-traumatic stress syndrome and probably two that may have been exposed to Agent Orange.

The CHAIRMAN. Do they have any problems related to the lifestyle of reservation living, or cultural differences?

Dr. CHAPPABITTY. Basically, the veterans that I have tend to return home and assume the lifestyle that they had before. The veteran status is something that just gives them additional status within the Indian community. They are very similar to the other patients I care for with regard to medical problems.

The CHAIRMAN. You closed your statement by recommending that the Indian Health Service and the VA identify the special needs of Indians, also to communicate with veterans to advise them of their special benefits? Are you suggesting that this is not being done at this time?

Dr. CHAPPABITTY. It may be being done. Many of the patients that I talk to I ask them if they are aware of the expiration dates, if they know about their VA status. The out-processing from the military may have included this, but it does not seem that they recall it. Whether somebody told them they did, they recall basically that they were told, but they are not sure what. Once they return to the Indian community, unless there is a strong veterans organization that will prompt them, these benefits are lost.

I interviewed a security man in my hospital Sunday morning. I just talked to him briefly. He had never used any veterans benefit, although he was a World War II veteran.

The CHAIRMAN. Does a national organization such as Disabled American Veterans, the American Legion or VFW maintain service offices in your hospital?

Dr. CHAPPABITTY. No, sir.

The CHAIRMAN. Do they have any relationship with your hospital?

Dr. CHAPPABITTY. None that I am aware of.

The CHAIRMAN. I appreciate your testimony, Dr. Chappabitty, because it comes not only from a veteran, but from a professional who has dealt with Indian veterans, and if we may—like Mr. Morris—may we submit to you a few questions for your study and consideration and response?

[Material to be supplied not available at time of printing.]

Dr. CHAPPABITTY. I would be most pleased, sir.

The CHAIRMAN. I thank you very much, Dr. Chappabitty.

Our next witness is Mr. Ted Twist.

STATEMENT OF TED TWIST, FORMER VETERANS SERVICE OFFICE, DIVISION OF VETERANS AFFAIRS, SOUTH DAKOTA, ACCOMPANIED BY ISAAC WHITEFACE, SHANNON COUNTY COMMANDER, AMERICAN LEGION, PINE RIDGE, SD

Mr. TWIST. Mr. Chairman, honorable members of the committee, I would like to apologize first, for the absence of Mr. Richards. Chuck had to leave suddenly for an emergency back home and whatever documents he prepared he took with him. So I am here to ad lib what his program might have been.

I am aware of what Mr. Richards had set up. This is the Indian Veterans Home Loan Program. He had worked on it quite a while. He had discovered primarily the same situation as Irving Billy and Dr. Chappabitty, that the programs that the Sioux have encountered are relative to their program.

This being, when they apply for the Home Loan Program, the loan organizations surrounding the reservations are hesitant to let them have funding for their home building. They request collateral, and this is rather an obstacle. It has been an obstacle since the G.I. loan has been available.

Our property is just like the rest of the members here, it is on Trust land. Recently we had been informed that there is a mechanism the BIA has to recover homes on Trust land. However, that was taken with the papers that Mr. Chuck Richards had. That was one thing he wanted to present here today.

In my tentative office, as former County Veterans Service Officer, I have processed approximately 215 eligibility loans to the individuals. Of that number, there were two of us that were able to use that Guaranty Home Loan program and have houses built on our property.

The CHAIRMAN. Only 2 out of 215?

Mr. TWIST. Yes, sir; that's an approximate number. The rest ran into the obstacle of collateral, employment, what have you got, what are your references? The work is scarce, but rather than stay with the program, they dropped it.

I have encouraged those that apply for that loan not to give up on it. If they stay with it, in the new programs that are coming

out, if there is anything available in there, we would approach the members or those program directors and see if we could get some financing through them.

However, that program or programs that are to be in place have not arrived. This is why we are stalemated at present.

The CHAIRMAN. Are you trying to tell us that because of the trust status of Indian land which results in the non-alienability of the land, because it cannot be mortgaged that Indians find there is great difficulty in getting loans?

Mr. TWIST. That's right, sir.

The CHAIRMAN. Does your tribe assist in providing collateral?

Mr. TWIST. They have not so far, sir.

The CHAIRMAN. Are they considering that?

Mr. TWIST. They are considering it, yes. It has been presented by the council numerous times, but I guess due to their finances too, it is on the table right now.

The CHAIRMAN. And so, in your tribe, in Pine Ridge, only two out of 215 were able to benefit from the loan guaranty program?

Mr. TWIST. That's correct, sir.

The CHAIRMAN. And how have they done?

Mr. TWIST. We are doing very well. Our payments are current, there is no obstacle. But our finances, of course, I am retired military, I draw a relatively comfortable retirement, and use a third of that to finance my home.

The CHAIRMAN. Gentlemen, I thank you very much. Mr. Twist, we will be submitting a few questions on the Home Loan Guaranty Program for you and how it applies to Indians. I hope you can respond to them.

Mr. TWIST. We will respond favorably, sir.

[Material to be supplied not available at time of printing.]

The CHAIRMAN. I thank you very much.

And now may I call upon the Principal Chief of the Seminole Tribe of Oklahoma and the National Commander of the Vietnam Era Veterans Intertribal Association of Shawnee, Oklahoma, the Honorable Jerry Haney.

Senator MURKOWSKI. Mr. Chairman, I wonder if while the panel is assembling, I may enter a brief statement into the record. I understand this may possibly be one of our last meetings prior to adjournment—on the other hand it may not.

The CHAIRMAN. This will be the last meeting, yes.

Senator MURKOWSKI. Would you indulge me for just 30 seconds?

The CHAIRMAN. Oh, yes; please.

Senator MURKOWSKI. You will recall that the Special Committee on Investigations of the Select Committee on Indian Affairs—which we authorized—we were to receive a report on specific recommendations. It is my understanding, Mr. Chairman, that as a member of this committee I am not aware that the report has been received.

It is my recollection that we were informed that the special committee would be producing its special report by some time this fall. We have no advisory information from the special committee that has been brought to my attention.

As you may recall, Mr. Chairman, I opposed the establishment of this special committee, favoring the investigation being done by the

Justice Department. Nevertheless, there was an overwhelming decision by the committee that we proceed.

Although the Select Committee on Indian Affairs created a special committee, most of what I know is from newspaper reports and I think, Mr. Chairman, it is appropriate that one would ask when members of the special committee will be briefed on the work of the special committee, when will its report be complete, what will be the nature of the report, and whether the final costs will be in the area of what was budgeted.

I think it is important that all of us who are on the committee have an opportunity to review that and that's the extent of my comments, and I ask that they be included in the record for the staff to reflect on.

The CHAIRMAN. May I assure you that the concerns and questions you have expressed are similar to mine. I will be having a meeting this afternoon with the chairman and vice chairman of the special committee, Senator DeConcini and Senator McCain, and I can assure you that the report will be on the agenda of our meeting.

Like you, I have no idea what the report states, I have no idea as to its recommendations, if any are being made, and I have no idea as to the findings. As you know. we made this an independent operation, and I await the report.

Senator MURKOWSKI. My concern, in addition, Mr. Chairman, is the appropriateness of the committee having a chance to review it—say in a draft form, or for whatever input we may have, not on the substance, because that is a job of the investigating committee, but just an overview of it, prior to its being finalized and released, which may or may not be appropriate, but I think at least deserves consideration.

The CHAIRMAN. As far as the release of the report, once it is made available to the members, there is no way of keeping it close to our vests.

Senator MURKOWSKI. I had in mind an oversight review where we would sit and be briefed on the draft. That's what I would like to see.

The CHAIRMAN. Let me assure you that we will have as many sessions as necessary for the special investigating committee to submit the report to us, brief us on this, and we will have a full discussion on it. The findings will be theirs, but the recommendations will be that of the full committee. So I can assure you that this matter will be fully aired by all members.

Senator MURKOWSKI. I thank the Chairman. I am satisfied by this.

The CHAIRMAN. As assumed by you, it will not be done this year. There is a good likelihood that if everything falls into place, we may be adjourning this Friday.

Senator MURKOWSKI. Wonders will never cease.

The CHAIRMAN. Although I will not hold my breath.

Senator MURKOWSKI. Thank you, Mr. Chairman for that sage advice. I am sorry to interrupt you.

The CHAIRMAN. Not at all.

And now, may I call upon the Principal Chief of the Seminole Tribe, the Honorable Jerry Haney. Chief Haney.

STATEMENT OF HON. JERRY HANEY, PRINCIPAL CHIEF, SEMINOLE TRIBE OF OKLAHOMA AND NATIONAL COMMANDER OF THE VIETNAM ERA VETERANS INTERTRIBAL ASSOCIATION, SHAWNEE, OK, ACCOMPANIED BY MATHEW KAULEY, EXECUTIVE DIRECTOR, VIETNAM ERA VETERANS INTERTRIBAL ASSOCIATION, SHAWNEE, OK

Mr. HANEY. Thank you, Mr. Chairman, and members of the Committee.

It is extremely important for us to talk with you today on these Indian veteran issues. Mr. Chairman, we recognize you as a distinguished war veteran. To the gentlemen of the Senate Select Committee on Indian Affairs, we deeply appreciate the efforts you and your committee have made concerning the Native American veterans.

We would like to thank you for calling these oversight hearings concerning Native American veteran's issues, and allowing us the opportunity to utilize this format to provide you with our testimony on behalf of the Vietnam Era Intertribal Association.

My name is Jerry Haney. I am the Principal Chief of the Seminole Nation of Oklahoma and National Commander for the Vietnam Era Veterans Intertribal Association. Accompanying me today is our Executive Director, Mr. Matthew Kauley.

As you know, the Vietnam Era Veterans Intertribal Association was founded in 1981 to promote and improve the lifestyle of the Native American veterans. Our organization has grown to a membership in excess of 1,200 members and continues to grow on a daily basis.

We feel this drastic growth is attributed to our ability to recognize how important our Native American cultural beliefs are to our target population group, and that our sensitivity to the Native American culture is a binding force that allows all Native American veterans an opportunity to participate.

It has been our experience that Native American veterans are reluctant to approach the Veterans Administration for services or assistance due to the Veteran Administration's lack of cultural sensitivity of the Native American veteran's needs. In addition, these cultural differences also prohibit Native American veterans from participating in other national veterans organizations.

Therefore, we have identified the problem: How can the VA meet the needs of the Native American veteran without recognizing the cultural differences of this target population group?

Mr. Chairman, I would like to inform you and the committee how we reached this conclusion.

In 1987, the Vietnam Era Veterans Intertribal Association developed a reorganizational initiative to allow for improved communications among the various chapters of the Association. In 1988, the proposed model was approved by the membership during the 7th Annual Conference and Pow-Wow held in Pine Ridge, South Dakota.

In 1988, the Association developed the newsletter entitled "Red Smoke". This will be our Attachment 1. This serves as a cultural information publication and recruiting tool to serve the Native American veteran.

In addition, the Association opened a national office for the purpose of coordinating and disbursing information to Native American veterans. The VEVITA national office is located in Shawnee, Oklahoma and the office maintains space for the VRW, VVA service representatives, and VA outreach counselor.

In May 1989 the Association participated in a national conference entitled "Encircling Our Forgotten," a mental health issues conference for the emotionally disturbed North American Indian child and adolescent. The title of our presentation was "The Vietnam Post-Traumatic Stress Disorder and the Native American Family." That report is our attachment 2.

In June 1989 VEVITA held the 8th Annual National Veterans Conference and Pow-Wow entitled "Native American Veterans: Have We Been Forgotten." As you will see, we have an Attachment 3 about that conference. Over 4,000 veterans, friends and relatives participated in that conference.

On October 4, 1989, the National Congress of American Indians called upon VEVITA to develop a 10-point plan to address veterans issues, as we have here in Attachment 4. VEVITA is a non-profit entity that depends on donations and in-kind contributions for support. The organization does not receive any Federal funds.

VEVITA was instrumental in the production of the following videos: "Shadow of the Warrior," "Warriors," produced by Deb Wallwork, and "Spirit of the Warrior" produced by Dr. David Rico.

Now, in contrast, I would like to show you, Mr. Chairman, what the VA has done starting in 1983. In 1983, the VA formed a national working group on Indian Vietnam veterans. In December of 1983, the working group decided to initiate a national survey of American Indian veterans for the purpose of starting the data-collecting process.

In 1986, the Consolidated Omnibus Reconciliation Act of 1986, Public Law 99-272, Section 19032 required the Administrator of Veterans Affairs to establish a VA Advisory Committee on Native American Veterans.

In 1988, the VA Advisory Committee on Native American Veterans submitted a final report to the Administrator of the Veterans Administration. This report is our Attachment 5. The Committee reported two major findings: The lack of data on Native American veterans and Native American veterans' underutilization of VA benefits and services.

In May 1989, Edward J. Derwinski, Secretary of the Department of Veterans Affairs approved the establishment of the Native American Veterans Advisory Committee and Coordinating Council.

In conclusion, Mr. Chairman, Native American veterans have always shared a bonding between their fellow brother and sister veterans. The Native American veterans need to participate in the services of the VA. However, we feel that the VA is not equipped to meet the needs of the Native American veteran.

Mr. Chairman, all we ask is that you oversee the executive branch and make them do their jobs. Here is what we propose: establishment of a Native American data base, establish a national veterans office to serve as a national clearinghouse, set up a national service officers training school.

We would like to see VA provide for cross-cultural training for non-Native American VA personnel, improve outreach efforts by VA Veterans centers to be located within Native American communities, that VA provide culturally sensitive information, provide a Native American desk within the VA and additional Native American staff.

We also ask that VA address PTSD, VA home loans for Native Americans, job development and placement, small business loans, homeless and incarcerated Native American veterans, mental health issues and employment opportunities.

Mr. Chairman, we would like to submit the attachments we have here into the record.

With that, Mr. Chairman, I conclude my testimony. Again, I would like to thank you for these hearings. Mr. Kauley and I will be willing to answer any questions you have.

[Prepared statement of Mr. Haney appears in appendix.]

The CHAIRMAN. Without objection, all of your testimony and attachments will be made a part of the record.

First of all, on the May 1989 establishment of the Native American Advisory Committee and Coordinating Council, how many Native Americans are members of this committee?

Mr. KAULEY. I believe they have yet to be determined, Mr. Chairman. We don't know the number—I believe the committee has yet to be determined—the number and who will compose the committee.

The CHAIRMAN. Have you been asked to submit any names?

Mr. KAULEY. No; we have not.

The CHAIRMAN. I will ask the representative of the VA. I have—like all the other witnesses before—questions I would like to submit to you. One question I would like to ask at this time is, as one of your recommendations, you ask that the VA provide culturally sensitive information. What do you mean by that?

Mr. KAULEY. I can cite as an example of culturally sensitive information our newsletter entitled "Red Smoke." A lot of the terminology we use within this publication, the format and the dialog of the printed matter in this publication are those types of information we know that our Native American brothers will read.

We know they will read this. They will not read VA literature. They have a hard time reading it. They are sort of boring, if you have looked at them. So we try to provide not only that, but also pictures of what the other veterans are doing, like in Arizona and South Dakota. We show their participation and what they are trying to achieve.

The CHAIRMAN. Do you receive any assistance from other veterans' organizations, such as the national ones, the VFW, American Legion, DMV, AMVETS?

Mr. HANEY. No, sir; we have a Native American service officer that has been trained by the VFW that has offered his time to us as a volunteer, but not through the VFW. He does that on his own. His knowledge and experience that he gives to us helps us to fill out paperwork.

The CHAIRMAN. You said we should have a national service officer training school.

Mr. HANEY. Yes, sir.

The CHAIRMAN. Right now, I think all the other organizations have their own schools, do they not? DMV has its own, VFW and others. What you are suggesting is a school established by the Department of Veterans Affairs?

Mr. HANEY. Yes; for our Native Americans.

The CHAIRMAN. What do you mean by the Native American desk? Is there any area within the VA for special desks?

Mr. HANEY. It is my understanding that there is no desk in the administration other than VA. That's what we were talking about. We had discussed it earlier.

The CHAIRMAN. Now, your organization is primarily veterans of the Vietnam era, is it not.

Mr. HANEY. Each chapter has their own bylaws. Some pick other veterans from other areas as associate members.

The CHAIRMAN. Do Indians have organizations covering the other wars?

Mr. HANEY. Yes; I know there are some. I don't think they are quite as large as ours.

The CHAIRMAN. Well, Chief, I thank you very much for your testimony. We will be submitting a few written questions. We would like to have you look them over and respond to us.

Mr. HANEY. Thank you very much, Mr. Chairman. We would be pleased to respond.

[Material to be supplied not available at time of printing.]

The CHAIRMAN. Next, we have the Assistant Secretary of Veterans' Employment and Training of the Department of Labor, the Honorable Thomas Collins. He is accompanied by Mr. John Meyers, the Deputy Assistant Secretary, and Dr. Steve Permison, Director of Patient Care Policy, Indian Health Service, Rockville, MD.

STATEMENT OF HON. TOM COLLINS, ASSISTANT SECRETARY, VETERANS EMPLOYMENT AND TRAINING, DEPARTMENT OF LABOR, WASHINGTON, DC, ACCOMPANIED BY JOHN V. MEYERS, DEPUTY ASSISTANT SECRETARY, VETERANS EMPLOYMENT AND TRAINING

Mr. COLLINS. Good morning, Mr. Chairman and members of the Committee. Thank you for inviting me to present the views of the Department of Labor on the employment needs and problems of Native American Indian veterans and our efforts to address them.

I am joined today by Mr. John V. Meyers, the newly appointed Deputy Assistant Secretary for Veterans' Employment and Training. Mr. Meyers brings with him a tremendous management background, and he is a decorated Vietnam war veteran.

John is also a Native American veteran, who has served as a member of the Department of Veterans Affairs Advisory Committee on Native American Veterans.

According to the Department of Veterans Affairs estimates, more Native Americans serve in the armed forces than their proportion of the overall population. There are about 170,000 Native American veterans, representing over 12 percent of the American Indian population. Many of them experience severe unemployment.

Those living on reservations have an unemployment rate of about 35 percent, with highs of up to 80 percent on some reservations. Off the reservations, the unemployment rate for these veterans is estimated to be in the 15 to 20 percent range.

Native American Indian reservations offer few opportunities for productive careers and far too little economic opportunity to meet the needs of their people. Efforts on the part of Federal programs to stimulate economic development depend on the cooperation and support of local governments to carry them out. Their success depends on the entrepreneurial, management and executive skills of Native Americans to carry out development projects.

Our efforts to assist Native American veterans to find jobs and obtain training is inseparably tied to economic development in their communities. The Veterans' Employment and Training Service does not have a direct mandate to develop the economic base and create jobs.

Our programs and other activities mandated by law are restricted to employment and training activities for veterans. Some of these serve specific targeted veteran subgroups, with several of our programs targeted to serve Native American veterans.

The Local Veterans' Employment Representatives program [LVER], and the Disabled Veterans' Outreach Program [DVOP], provide grant funds for personnel in State Employment Service offices across the country.

Although those offices must provide priority services to veterans by law, the LVER and DVOP staff serve veterans exclusively and have received professional training in vocational guidance and counseling, veterans' reemployment rights, benefits, entitlements, and other training to provide quality assistance to veteran applicants.

The CHAIRMAN. May I interrupt you as we go along?

Mr. COLLINS. Yes, sir.

The CHAIRMAN. On the last paragraph on the Veterans' Employment Representative Program, the Disabled Veterans Outreach Program—you provide training programs?

Mr. COLLINS. We provide the professional employment training to DVOP and LVER personnel. They are trained in vocational guidance and counseling. They are also trained in veterans benefits, and the other employment programs.

The CHAIRMAN. If the law were amended to include Native American Indians for training purposes, would your agency be equipped to provide the special training?

Mr. COLLINS. We do not have a special Native American training program now. However, under the IV-C program, we would be able to develop such a program.

The CHAIRMAN. Are you planning to do so?

Mr. COLLINS. We have some on-the-job training and other types of training in some of the programs that are underway and that had been developed in the past. The paragraph that I just referred to is a type of training that we provide to our employment representatives, the DVOPs and LVERs, so that they may carry these services to all veterans. Some Native American veterans are employed as DVOPs and LVERs.

The CHAIRMAN. So it is provided only to your employees?

Mr. COLLINS. The training that will enable them to be professional guidance counselors, and benefit counselors is given to our DVOPs and LVERs so that they may service the entire veterans community.

The CHAIRMAN. But if we extended this to include not only your employees, but Indian candidates whose names would be submitted by tribes, you could do that?

Mr. COLLINS. I would need to prepare a more detailed response to that, but yes, sir, I would agree in principle that we can do that. Taking representatives from the Indian nations and giving them the same training that we give all the DVOPs and LVERs would be a very worthy thing to do .

The CHAIRMAN. Wonderful.

Mr. COLLINS. I believe we could work that out.

The CHAIRMAN. Could you prepare a paper on that for us, please?

Mr. COLLINS. Yes, sir; I would be more than happy to provide more information and work out a plan for that.

The CHAIRMAN. Thank you very much.

Mr. COLLINS. My office also administers the employment programs dedicated specifically to veterans under the Job Training Partnership Act [JTPA] Title IV, Part C. The title IV-C program funds training, such as classroom and on-the-job training, and other employment-related assistance.

Our Homeless Veterans' Reintegration Projects are funded by the Stewart B. McKinney Homeless Assistance Act and provide for outreach workers to find and help homeless veterans obtain employment. All of these activities focus on helping veterans find jobs or move into better jobs.

For several years, the Veterans' Employment and Training Service has undertaken efforts to address the employment problems of our Native American veterans. Over the past few years, we have intensified these efforts and broadened the types of approaches we are undertaking to discover new solutions to their employment problems.

Our title IV-C program for the current year includes American Indian veterans. Although the program restricts the funding of positions which duplicate the efforts of DVOPs and LVERs, exceptions are made in those cases where outreach activities are being conducted to serve Native American veterans.

Our title IV-C program in Wyoming provides specific outreach services to the Wind River Reservation where unemployment among Native American Indian veterans may be as high as 90 percent. The program enrolls the veterans in a mix of remedial education, classroom, and on-the-job training. The State Employment Security Agency has also committed a Disabled Veterans' Outreach Program specialist to serve on this very large reservation.

Our staff in Arizona and New Mexico have been working with the Navajo Nation and other tribes having a common border with these two states. Recently the State of Arizona provided a full-time LVER and four part-time positions to the Navajo Reservation, and we added special funding for New Mexico to provide training to Native American Indian veterans.

In Hawaii, an outreach program was undertaken two months ago, jointly by the Department of Veterans Affairs, and the Veter-

ans Employment and Training Service to develop more outreach activities targeting Native Hawaiian veterans for training and job placement activities. The program plans to make use of the VA's Vet Centers as a single point of contact for services from all three cooperating agencies.

The CHAIRMAN. Are these pilot programs, or do you plan to expand this to cover other tribes and nations?

Mr. COLLINS. Sir, these are pilot programs, and following evaluations, we do plan to continue these in other areas to other nations.

The CHAIRMAN. Does the initial evaluation show success?

Mr. COLLINS. I did not bring with me today any detailed evaluation report, and many are still underway. I will be happy to report to the Committee any details about ongoing and future evaluations which are, in many cases, the most critical element of pilot projects. This is where we obtain our information on ongoing needs and what Vets should be doing in the future, toward establishing permanent employment services programs.

The CHAIRMAN. The committee would be most interested in receiving that.

Mr. COLLINS. Yes, sir.

In August 1988, we funded the development of a handbook for employment and training service providers entitled "The American Indian Veteran: Perspectives and Methods to Provide Employment and Training Outreach." This culturally attuned handbook provides advice on improving ethnic relations in the effort to assist Native American veteran constituents.

The CHAIRMAN. Has this handbook been made available to all Indian tribes and nations?

Mr. COLLINS. Sir, I cannot tell you that it has been made available to all of them. That was its purpose. As a suggestion, I will report to you on the distribution of this handbook.

The CHAIRMAN. May we have a copy of that, also?

Mr. COLLINS. Yes, sir; we will submit a copy for the record and for your own use.

We awarded a $200,000 grant to the National Congress of American Indians in May 1986 to promote entrepreneurship as a way to develop jobs for Indian veterans. Working closely with the Small Business Administration, this project conducted business development seminars in states with relatively high Indian veteran populations.

In 1984, we contributed $50,000 to the Presidential Commission on Indian Reservation Economics.

We have been an active participant of the Department of Veterans Affairs Advisory Committee on Native American Veterans and endorsed the Committee's report, particularly the recommendation that a National Native American Veterans Coordinating Council be established.

Unemployment for these veterans almost always results from multiple problems not normally addressed by our Title IV-C employment and training programs. These problems include medical and psychological problems, substance abuse, family conflicts, legal hassles, obstacles to obtaining benefits and entitlements.

It is necessary to coordinate our efforts with the other agencies and supportive services to solve the unemployment problems of our

Native American veterans. In many cases, these problems must be addressed and solved before the veteran can receive any employment-related services.

The Coordinating Council will be able to create solid, formal commitments to put them into practice wherever it is appropriate. The Council would also be able to promote economic development activities on behalf of other agencies.

On and off the reservations, our Native American Indian veterans need special attention and I intend to continue to commit our program plans to developing effective methods of addressing their severe employment problems.

This concludes my statement. Thank you again for the opportunity to discuss the problems of these veterans with you and to give you some idea of our assistance and resolution. I will be pleased to answer any questions you have on this matter.

[Prepared statement of Mr. Collins appears in appendix.]

The CHAIRMAN. Mr. Secretary, I thank you for your testimony. I would like to assure you that this committee stands ready to work with you in providing special attention to the special needs of Native American Indians. I look forward to studying your handbook, in particular. I assume from the testimony of Chief Haney that he has not seen that handbook.

Chief Haney, have you received that handbook?

Mr. HANEY. No.

The CHAIRMAN. Do you know anything about that handbook?

Mr. HANEY. No.

The CHAIRMAN. Well, you will get a copy this afternoon.

Do you know whether the Veterans Administration has formed that Advisory Council that was authorized this year?

Mr. COLLINS. I do not believe, sir, that the Council has been formed yet, but it is in the process of being formed.

Mr. MEYERS. We have gotten the news release that the Indian Council will be formed, and we are advised that a letter will be coming to us asking for our nominee.

The CHAIRMAN. What will be the makeup of this Council?

Mr. MEYERS. Sir, we cannot respond to that. To date, have been asked for the Department of Labor's nominee only.

The CHAIRMAN. Does the directive suggest that your nominee be a Native American, or not?

Mr. MEYERS. Not to my knowledge, however, I have been informed that I will be the nominee to the Committee.

Mr. COLLINS. I informed Mr. Meyers that he will be our nominee just yesterday.

The CHAIRMAN. Congratulations.

Mr. MEYERS. Thank you, sir.

The CHAIRMAN. I thank you very much, Mr. Secretary.

Now I will call on Dr. Steve Permison.

STATEMENT OF DR. STEPHEN PERMISON, DIRECTOR OF PATIENT CARE POLICY, INDIAN HEALTH SERVICE, ROCKVILLE, MD

Dr. PERMISON. Thank you, Mr. Chairman and members of the Committee. I am Dr. Stephen Permison. I am the Director of Patient Care Policy for the Indian Health Service.

I am pleased to be here with you today to discuss the efforts of the Indian Health Service to meet the needs of the Native American veterans. Rather than read my testimony, I will go through it and highlight it, and submit my written testimony for the record.

The CHAIRMAN. All statements will be placed in the record in full.

Dr. PERMISON. The Indian Health Service is a Federal agency charged with administering the principal health programs for Native American Indians and Alaskan Natives. The goal of the Indian Health Service is to raise health status to the highest possible leve'.

IHS's mission is three-fold, to provide or assure the availability of high quality, comprehensive, accessible health services, to provide increasing opportunities for Indians to manage their own programs, and to serve as a health advocate for the Indian people.

This year we will continue to focus on quality assurance, community-based comprehensive care and the commitment to support activities that reduce health risk factors as well as treat diseases.

IHS is also continuing to increase its emphasis on the strengthening of the tribal health care delivery systems. This is a key factor in examine new or improved cooperative arrangements that meet the needs of any Indian community or special group, such as Indian veterans.

Presently we have a variety of associations that exist between the Veterans Administration and the Indian Health Service. Needs can be identified both at both the individual facility level, and the area level.

The IHS recently has received authority to provide and bill non-Indian veterans and other non-IHS beneficiaries for health services provided at our facilities. This authority is provided under Public Law 100-713, the Indian Health Care Amendments of 1988.

We may provide these services as long as several requirements are met. Those are that the affected Indian tribes agree to the provision of care to the non-Indian beneficiaries, and that provision of those services does not result in a diminution or denial of health services to eligible Indians, and that there are no reasonable alternative health facilities available.

A further condition, actually enablement of the provision of these services, takes place under Public Law 638. Self-determination contractors may provide these services at the discretion of the contractor.

Beyond the facility level, service areas within the IHS have also developed a variety of shared resource agreements. Such arrangements are fueled not only by economic necessity, but also by the professional advantages. These are the kinds of advantages that are reaped our professional staffs, both from the VA and the IHS, intermingling together and sharing ideas and concepts.

Some other examples of these shared services would be credentialling of IHS physicians at VA hospitals, and shared continuing medical education, and then at the facility level, shared utilization of actual facilities, such as support services for more intricate or specialized hospital care that might not be available at the facility level, such as utilization of surgical suites, surgical services, medical intensive care, ICU, et cetera.

Since IHS provides a comprehensive array of services ranging from preventive education, clinical care and safe water systems, an Indian patient receiving such services is often involved in a continuum of care. This continuum of care is not normally provided through other health care organizations.

However, as in the case of the Veterans Administration medical services, they may be able to better provide specialized—that is, a local facility—may be better able to provide the specialized types of services I mentioned previously.

Additional examples of such treatment would include burn treatment, aesthetic and physical rehabilitation therapy, and other kinds of treatment that may not be available in the typical rural facility at the Indian Health Service has available, or maintains.

In conclusion, Mr. Chairman, IHS is committed to seeking ways of improving its services to all Indian people. Within IHS's target population, veterans have a most special place and deserve assurances that their unique needs will be identified and properly treated. The Indian Health Service intends to continue to fully explore and promote those actions necessary to accomplish this goal.

Thank you, Mr. Chairman. I will be happy to respond to any questions.

[Prepared statement of Dr. Permison appears in appendix.]

The CHAIRMAN. Thank you very much, Dr. Permison. In summary, you have indicated that because of the unique economic factors and geography and because of the fact that the Indian Health Service is the primary source of health care for Native American Indians, you felt it necessary to enter into special agreements with the VA in order to provide the full array of medical services to our Native American Indian veterans.

Are you satisfied that your agreements now provide the full array of services to Native American Indian veterans?

Dr. PERMISON. Mr. Chairman, I think that we are now at a threshold of an opportunity where we might expand those agreements to look at those which have already been put into place and see what services might be better shared and so I believe that a review of the existing services will lead to an ever-increasing sharing of future services.

The CHAIRMAN. Are the beneficiaries—the veterans—aware of these services? This is one of the problems we have. There are many benefits that are mandated and passed by this Congress, and unfortunately, many of the beneficiaries are not aware of them. One would think that the veterans would have heard about educational benefits, but we have come across men and women who have come to us and told us that they just found out about them.

Are you able to communicate with the Indians as to the special services that are available?

Dr. PERMISON. Our communication would take place at two levels. First there would be the widespread dissemination of this type of information, which I think we can look to the Veterans Administration or hopefully look to them to help us disseminate.

Second would be at the level of the facility which the patient enters for care, the Indian Health Service facility, or the veterans facility. Again, after review of what is in place currently, we might

find—and I would not be surprised to find—that we can do a better job at disseminating this information.

I can speak from professional experience, when I was a clinical director in the field at a 40-bed hospital. One of the problems that we see is that our patients are not as fully informed as we would like to see them informed, not only about veterans benefits, but about our entire beneficiary package.

The CHAIRMAN. Are all of the directors of the Indian Health Service clinics throughout this land fully advised and knowledgeable of these services?

Dr. PERMISON. Mr. Chairman, we have now underway an effort to more fully advise our facilities in our areas. This will take place at our next clinical directors and chief medical officers meeting beginning December 3. The associate director for the Office of Health Programs will be speaking to the issue of veterans affairs and the availability of services.

The CHAIRMAN. So you are suggesting that even if these services are available, there are many Indians who are not aware of them, and will therefore be denied them?

Dr. PERMISON. I would like to say that there has to be a continuum of information. The cycle, if it lapses for 1 year or lapses for several months, the information may not be carried forward. So I am sure that there are people who are not aware, yes, sir.

The CHAIRMAN. Do you have any formal communications with all the tribes and nations, so that you could automatically send out handbooks, or copies of agreements?

Dr. PERMISON. We have within the Office of the Director of the Office of Tribal Affairs a list that does list all tribes. We are in a position to disseminate information to all tribes.

The CHAIRMAN. Are they doing this? Specifically with regard to your activities in sharing of services, or availability of services?

Dr. PERMISON. We are in the process now, Mr. Chairman, of putting together this information for dissemination on December 3. We will certainly include—and we would look to them, because they are the holders of the distribution list.

The CHAIRMAN. How long will it take to distribute this?

Dr. PERMISON. The effort now at this point is an information-gathering effort.

The CHAIRMAN. But they will be completed by the third of December?

Dr. PERMISON. I don't want to give you misinformation, Mr. Chairman. We are presently underway with an information seeking effort that will go to the chief medical officers and the National Council of Clinical Directors for information. We are asking them to provide us information.

We are trying to establish a catalog of facilities that are shared. The agreements are of many different types. Some are informal agreements, some are formal. It is the cataloging of these agreements that we will be initiating at the meeting on December 3.

The CHAIRMAN. I will be most interested in the outcome of that meeting on December 3. Will you provide me with a memo on that?

Dr. PERMISON. Most certainly.

The CHAIRMAN. I thank you very much, sir.

Dr. PERMISON. Thank you, Mr. Chairman.

The CHAIRMAN. I would like to at this time call upon the Director of Veterans Benefits of the Department of Veterans Affairs, the Honorable R.J. Vogel. Director Vogel will be accompanied by Arthur Lewis, Deputy Chief Medical Director, Veterans Health Service, and Mr. Allen Clark, Assistant Secretary, Veterans Liaison and Program Coordination, and Mr. John Fulton, Chief of Social Work Services.

STATEMENT OF R.J. VOGEL, CHIEF BENEFITS DIRECTOR, VETERANS BENEFITS ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS, WASHINGTON, DC, ACCOMPANIED BY DR. ARTHUR LEWIS, DEPUTY CHIEF MEDICAL DIRECTOR, VETERANS HEALTH SERVICES AND RESEARCH ADMINISTRATION; ALLEN CLARK, ASSISTANT SECRETARY, VETERANS LIAISON AND PROGRAM COORDINATION; AND JOHN FULTON, CHIEF OF SOCIAL WORK SERVICES

Mr. VOGEL. Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Director, I welcome you, sir.

Mr. VOGEL. Thank you. I have an abbreviated statement I would like to read and ask that the full statement be made a part of the record.

The CHAIRMAN. I assure you that the full statement will be made a part of the record.

Mr. VOGEL. My colleagues and I are pleased to be with you this morning to provide testimony on VA programs and efforts to meet the needs of Native American veterans. As you know, VA is a cabinet-level department responsible for administering a broad spectrum of benefits to assist eligible veterans, their dependents and survivors.

I am directly responsible for our monetary benefits programs, as the head of the Veterans Benefits Administration, while our medical care programs fall under the operational responsibility of my colleague, Dr. Arthur Lewis, the Deputy Chief Medical Director.

As I will explain shortly, one of our most far-reaching initiatives relating to service-delivery to Native American veterans is under the leadership of Mr. Allen Clark, our Assistant Secretary for Veterans Liaison and Program Coordination whom I am also pleased to have with me.

Overall, VA programs have a far-reaching national impact on veterans generally, as well as on Native American veterans. In serving millions of veterans annually, however, we must be cognizant of and responsive to the needs of those diverse, sometimes overlapping, groups.

These include veterans with service-incurred disabilities, the growing population of aging veterans, women veterans, Vietnam veterans, former prisoners of war, and homeless veterans, to name but a few who have a distinct and rightful claim to VA's attention and concern.

The often diverse needs of those groups present real and sometimes formidable challenges, particularly in times of fiscal constraint and competing demands for resource commitment. In that regard, we are sensitive to the special needs and concerns of Native American veterans and are indebted to the work of the VA Adviso-

ry Committee on Native American veterans for their significant contribution to our department.

The principal findings and recommendations of the committee provide a clear agenda for the Department of Veterans Affairs and sister Federal departments serving Native American veterans. Let me focus, in that connection, on what I believe is perhaps the most important of the Advisory Committee's recommendations, that VA establish a national Native American Veterans Coordinating Council.

VA agrees with the Committee that there is a clear need for Federal agencies to coordinate programs and resources in providing for the Native American veterans. Let me note that VA has been pleased to be an active participant in the White House Native American Indian inter-agency task force, which was recently formed to facilitate communication and information among all Federal departments providing services to Native Americans.

This important Administration effort has highlighted the need for a central point of coordination for services provided to Native American veterans.

I am also pleased to report in that regard that Secretary Derwinski has initiated a council on Native American veterans to promote and coordinate programs and services for Native American veterans. Departmental responsibility for the Council has been assigned to the Office of Mr. Allen Clark. We are inviting other Federal agencies serving Native American veterans to participate.

We view this new entity as important, not simply because it will help assure that diverse Federal efforts are better coordinated, but because we believe no one department or agency can do enough to solve such profound problems as unavailability, inaccessibility and underutilization of services, as described by the Committee.

We believe the time is right to build on the work of the Advisory Committee and to capitalize on the momentum and interest among the involved Federal partners.

The CHAIRMAN. May I interrupt at this stage? Has this Council been formed?

Mr. VOGEL. It is being formed as we speak. The Secretary has informally designated Mr. Clark to head that up, and is now inviting participants from Federal entities. Mr. Clark may want to speak to that for a moment.

Mr. CLARK. The Secretary is going to be signing letters that are on his desk now to invite other groups that are going to be participants, which are Veterans Health Services and Research Administration, our benefits group, the Department of Labor, the Bureau of Indian Affairs at Interior, HUD, OPM and the Health Services at H&HS, will be direct participants.

It is our intention to add six combat veteran consumers onto the committee also, so that we can have direct consumer input as we go through our recommendations to make sure they will work. We hope to have a meeting before Christmas, Mr. Chairman.

The CHAIRMAN. I realize that this is an inter-agency type committee, but do you plan to have Native American Indians participate on this Committee?

Mr. CLARK. Yes. The six combat veterans I mentioned, Mr. Chairman.

The CHAIRMAN. Six of them?

Mr. CLARK. Yes.

The CHAIRMAN. How will they be selected?

Mr. CLARK. The Secretary will make the selection. I just saw Chief Haney, and went out and gave him the Secretary's address, and said for him to send any recommendations he has as an example, and we will send out some other letters to get recommendations from our Advisory Committee members, plus other people within the Native American veteran community to give us some other recommendations.

We have some people that have already asked to be on it, so we have some names on our files already.

The CHAIRMAN. So you will be having Indians on board?

Mr. CLARK. By all means. There will be six Native American combat veterans on that committee, Mr. Chairman.

Mr. VOGEL. While we feel a good and compelling need to establish that coordinating group that Secretary Clark spoke of, I would like to cite a few examples of some of our successes.

In the area of outreach, our benefits programs are administered through 58 regional offices, which are supported by Veterans Services divisions. Their work is essentially outreach. I have directed our offices to mount efforts to reach out to the Native American veterans and found that most of those stations serving significant Native American populations have outreach efforts which are either planned or ongoing.

Significantly, our field experience suggests that regional tribal and cultural differences among Native Americans make it inadvisable for us to superimpose a specific outreach formula. We are instead encouraging our offices to tailor an approach to fit the needs and concerns of the local groups.

Several of our facilities have also established local advisory committees through which Native American groups provide advice or coordination in connection with ongoing or planned programs. For example, the VA medical center in Hot Springs, South Dakota, has established a Native American Advisory Committee that has developed and implemented a sharing agreement with the Indian Health Service Hospital in Pine Ridge, and has been meeting with IHS representatives to plan and coordinate provision of inpatient and outpatient services for our joint constituents on the surrounding Sioux Reservations.

Our Honolulu regional office and outpatient clinic has developed a committee for Hawaii and Pacific Island natives. It is working jointly with the Office of Hawaiian Affairs and the state of Hawaii in developing these special medical programs and outreach efforts.

Our formal statement details a number of other examples which are illustrative of the establishment of local committees, sharing agreements with IHS hospitals, and the development of special programs. We realize, of course, that Native American and other veterans may live considerable distances from our VA medical centers, as discussed in our statement.

We have made headway in serving these rural areas, and such target groups as Native American veterans, through several mechanisms. This includes the activation of outreach clinics, and estab-

lishment of community-based clinics and counseling centers for Vietnam era veterans.

In conclusion, we believe VA has played an important role in providing benefits and services to Native American veterans. But the findings of our Advisory Committee, frankly, state that there remains much to be done. While we have taken important steps forward, we intend to continue to work with other government agencies and the Native American veterans on the Federal, state and local level to continue the progress we have made.

Mr. Chairman, that concludes my statement. My colleagues and I would be pleased to respond to any questions or concerns you have.

[Prepared statement of Mr. Vogel appears in appendix.]

The CHAIRMAN. I thank you very much, Mr. Director.

As you know, I am a veteran of World War II, and one who is most grateful to my country for the services I have received throughout the years. As a result of veterans benefits, I have completed my undergraduate and graduate work.

I have received everything from a free automobile to housing allowances, and on and on. I was able to get all of this because I happened to live in an urban area, where within walking distance was a VA office, and the service officers were always available to me.

In this case, we have Indians who live in distant parts of this country, on reservations, not within walking distance. It takes an extra effort, either by plane, or something like that, to even visit a VA office.

Second, because of its distance and size, our agencies have not seen fit to have field representatives there because of cost-considerations.

Third, as you have heard from other witnesses, somehow the lines of communication have not always worked. So we find, I would say hundreds upon hundreds of Native American veterans who are really not aware of the many benefits that you are prepared to provide them.

Do you have a system of communicating with reservations and tribes and nations?

Mr. VOGEL. There is a network out there that goes far beyond VA and even some of the other agencies that you heard from, such as the Department of Labor. There are the National Veterans Service Organizations, which have service officers in communities throughout the country. Those States have county service officers as well. Through those mechanisms, we attempt to get the word out and be helpful.

I spoke this morning to the director of our Muskogee regional office who informed me that the group that is headquartered in Shawnee, Oklahoma, has asked for assistance from the regional office in the training of their own service officers to make that process you have referred to—the difficult nature of getting information out—more effective.

A lot of the solutions to information dissemination can be made by people who work with us, even if it is not us directly. We frankly would be stretched far too thin, considering the resources we have, to be present in such a large country as America, especially when you consider the scope and size of Alaska.

We think the effort can be augmented by others who are as concerned as we are. We will, and in fact do, provide training to make sure that information dissemination is effective. Every veteran discharged from service today gets from us a mailing once he gets home that advises him of his benefits, what he is entitled to, and explains how he can access that.

We have toll-free telephone service. There is a telephone every place in the United States, and you can reach the VA for the cost of a local call.

The CHAIRMAN. I have had discussions with literally hundreds of Native American veterans on reservations throughout this land. Most of them have told me that they would never take advantage of the VA hospital. First, it is too far away. Being so far away, they feel that if they ever entered that hospital, it would be to die, because the hospitals are so far away that they cannot afford to have their families visit them.

Are you making an effort to make certain that these health services are available on the reservations? We were discussing the shared services with the Indian Health Services.

Dr. LEWIS. To a limited extent, Senator, yes, we are. I think Mr. Vogel has indicated to you our programs that we have in place at Hot Springs, and also in Hawaii. I think you are aware of the fact that we have instituted four outreach centers in the Hawaiian Islands—I think they were referred to earlier. They are functioning as outreach centers on three of the islands at the present time.

We do have an arrangement at Albuquerque which includes an Indian advisory committee with Federal agency, tribal and State and local representation. There has been an outreach program established in Gallup, New Mexico, and there is joint planning between the VA and the Indian Health Service resulting in outreach staff being assigned to seven IHS hospital sites in the Navajo Reservation.

We have joint agreements in St. Cloud, Minnesota, with the Indian Health Service. We also have designated beds for the post-traumatic stress treatment and homeless program at American Lake, in Washington. Also, we have an outreach clinic on the Indian reservation at Miles City, Montana, to bring patients into the program up there.

More recently, we have negotiated an agreement with the Indian Health Service down at Asheville, North Carolina, to take patients into that hospital down there that cannot be cared for at the Cherokee Hospital. So these are activities we have underway.

We have attempted to involve the directors of our 172 medical centers and outpatient clinics in terms of the recommendations in the report of the Native American Advisory Committee by sending copies of that out with instructions that it should be implemented within available resources and an attempt be made to bring as many individuals into the hospital as possible, and to negotiate affiliation agreements with the Indian Health Service to assist as many Native American veterans as possible.

The CHAIRMAN. As you know, the States of Alaska and Hawaii do not have VA hospitals at this time, but we do have special arrangements with the military hospitals in our area. Alaska has a

problem of distance and geography, and Hawaii has this problem of different islands.

So we are looking forward to great contributions by these outreach centers. I presume this is a pilot program, is it not? You are going to be assessing the success of these programs?

Dr. LEWIS. I don't really think the outreach centers as such are pilot programs.

The CHAIRMAN. Do you intend to have outreach centers in these reservation areas?

Dr. LEWIS. There is no specific plan to increase those at the present time. There are a defined number which are currently in operation.

As a matter of fact, I do have some specifics which indicate that at the present time, we have 13 medical centers with outreach efforts to Native Americans and three of the veteran's Readjustment Counseling centers regularly visit Indian reservations.

So the outreach efforts and the sharing programs are actually functioning at this time. Obviously, it would be better to expand these programs and we will continue to encourage that, but there are no immediate plans for new outreach centers.

The CHAIRMAN. Can you share with this committee the approximate cost of each of these centers? What would be the cost to expand them?

Dr. LEWIS. The approximate start-up cost for each of the Outer Island Primary Care Clinics was $443,000. The approximate annual cost of each clinic is $534,000.

The CHAIRMAN. I would like to see that our First Americans get the same breaks that I got. They have done a lot for this country, and the least we can do is provide them with benefits that all of us are entitled to.

With that, I would like to thank you, Mr. Vogel, Dr. Lewis, Mr. Clark, and Mr. Fulton. I will be submitting, if I may, questions relating to statistics and technical information. I hope that you will look them over and respond to them.

Mr. VOGEL. We would be pleased to do so, Mr. Chairman, and thank you very much.

[Material to be supplied not available at time of printing.]

The CHAIRMAN. Thank you.

Our final panel consists of the Chairman of the Native American Veterans Advisory Committee, Mr. Raymond Field, and a member of the Native American Veterans Affairs Advisory Committee of Hawaii, Dr. Samuel Apuna.

May I first call upon Chairman Field. Welcome, sir.

STATEMENT OF RAYMOND FIELD, CHAIRMAN, NATIVE AMERICAN VETERANS AFFAIRS ADVISORY COMMITTEE, SILVER SPRING, MD

Mr. FIELD. Good morning, Mr. Chairman. On behalf of Native American Veterans, thank you for bringing a Congressional focus on the problems facing Native American veterans in getting services to which they are entitled, which they have earned.

It is always peculiar to me how, in wartime, where there are needs for warm bodies in outposts and trenches that the Federal

Government can find American Indian veterans, sending recruiters to reservations, to get volunteers, to get enlistments from those reservations. They can find us during times of combat.

But when Native American Veterans need the benefits which they have earned, then there are all kinds of excuses, citing inaccessibility to reservations. We are not getting the same equal treatment as the general population. It is ironic that that happens.

I think the evidence of why it happens is clear. If you observe the hearing room, there is no Bureau of Indian Affairs representative from the central office. The advisory committee has been very disappointed by the lack of participation by the Bureau of Indian Affairs. The sole, principal Federal agency that is charged with the care of the Indian people does not even deign to participate in an active way with this committee in its deliberations during the two and a half years of its existence.

This is a fine way to say thank you to Native Americans, whether they are Hawaiians, Native Alaskans, or American Indians.

I would like to address the home loan issue. I was shocked as I sat back here and heard Mr. Isaac Whiteface say that he had obtained a home loan guaranty on a reservation. Actually there were two. After he left, I ran outside to talk to him. During our deliberations, Mr. Chairman, the committee, members could not identify a single home loan guaranty obtained by an American Indian Veteran on a Federal reservation.

Outside, Mr. Whiteface told me he had obtained his in 1946, right after the war, which explains why he got it. Also, his land is in fee patent, not trust status. So our findings are still true. We cannot find a single home loan guaranty conferred on an American Indian veteran, on a Federal reservation.

One of our principal recommendations early on was to re-implement the direct home loans program. That is still a feasible idea. I know that many lending institutions and the Department of Veterans Affairs use the reason for denying direct home loans as the lack of non-alienability or severability of the home site from the reservation.

There is in existence a 1965 memorandum of understanding between the Veterans Administration and the Bureau of Indiana Affairs in which the requirement for non-alienability and severability is waived. Insofar as we know, that understanding is still in existence. There is also the problem of attitudes of lending institutions. There is, by way of operation, red-lining occurring in Indian country, where banks will not lend to people residing on reservations.

I think a lot of the problem is attitudinal. I would like to cite to you a single incident that this committee experienced in Albuquerque, VA. A regional loan officer—whom I will not name, but he knows very well who he is—in the Albuquerque area testified before our committee. He presented a loan package using a case study method. It was about 3 inches thick.

He told us to look at it, and then he would tell us exactly why he turned this Indian veteran down. He said "Many Indians come to me, and they have the wrong idea, that this is a right. That this is not a right but must be earned to a home loan guaranty." He was not talking about it being a service, or providing sufficient collateral, et cetera. He was talking about the fact he felt we had not earned it.

I quickly pointed out to him that the members of the combat veterans sitting on that committee had earned the right to it. We have earned the right to it.

He further stated that he had performed Indian veterans a favor by turning them down. So he denied to us the right to failure, whereas for white veterans, you can do that.

To me, this country is not bearing out its responsibilities. To reiterate, the direct home loan guaranty is still on the books, it is still an active law. It is provided for when no other lending institutions can be obtained.

I would like to move on to PTSD. We have just a brief statement on PTSD. In our deliberations through Indian country, Washington, DC, and Hawaii, we had a lot of veterans come before us and testify from those regions about their need for care.

They would come and unburden themselves. It was an emotionally evocative experience for all of us, because we understood exactly what they meant. A lot of things they did not have to say, but we understood.

One of our principal needs is to have a PTSD study conducted in behalf of our Veterans. The VA, in their reply to our request to have a PTSD study, said that they had sufficient information where they can extrapolate for us. But we are different. Our culture is different. We are located in different geographical situations, on islands, reservations, remote areas. How can they extrapolate that?

We had asked for, and with the support of the two senators from Hawaii, got $1 million set aside for a PTSD study to be done on Native American veterans, Hawaiians, Alaskans, and Native American Indians. In a conference about 5 weeks ago, that $1 million was lost. It was moved on to another area.

I started to question the individuals who did that. Maybe they don't think we have the same problem, maybe they think we don't suffer the same consequences from combat, or to see people ruined and torn. Maybe they think we are impervious to that.

I would urge the members of the Senate, and certainly the Senate Veterans Affairs Committee has been supportive of our committee, to restore that $1 million so that we can get on to addressing the problems that these men face.

As you heard from the VA, the National Native American Coordinating Council is about to be implemented. We did, at a meeting late yesterday, meet with Allen Clark, the Assistant Secretary from DVA who just spoke, and asked for the committee to be comprised of assistant secretary level persons, so that decisions can be rendered and discussed at a high level, and also to balance our concerns for Native American veterans to see that eventually the bureaucratic reluctance could be put aside.

We asked for six combat veterans to be placed on that council, and it was agreed to. So we have great hopes on that issue.

We met last December in Hawaii. Under Public Law 100-322, the committee was expanded to include Hawaiian veterans. Certainly, Dr. Sam Apuna, a colonel in the United States Army, has brought a lot of knowledge and expertise to our committee, besides a great sense of humor. I would like to turn this over to Dr. Apuna.

[Prepared statement of Mr. Field appears in appendix.]

The CHAIRMAN. Before I call upon Dr. Apuna, may I ask a few questions?

Mr. FIELD. Yes, sir.

The CHAIRMAN. You opened your remarks in a most telling fashion. You said that our country went to extraordinary means and very successfully encouraged Native American Indians to volunteer in large numbers. As we all know, Indians comprise one-tenth of 1 percent of the population, but the veteran population consists of six-tenths of 1 percent. So your numbers are six times that of other ethnic groups, and all other American veterans.

Are they still sending recruiters to reservations and tribes and nations?

Mr. FIELD. Yes, sir; they make themselves available to go out to reservations to the tribal and BIA offices.

The CHAIRMAN. How often do they come around?

Mr. FIELD. I do not know, sir.

The CHAIRMAN. But they come around often?

Mr. FIELD. Yes; I have been on reservations when they have been there recruiting. They give out lists of the educational benefits, and so on, home loan guarantees available to the veterans when they have completed their service.

The CHAIRMAN. So the Department of Defense is very active in sending personnel out there?

Mr. FIELD. Yes, sir; we are warm bodies for war.

The CHAIRMAN. Would you say that other agencies put in an equal amount of effort to visit your people?

Mr. FIELD. Are you speaking of the agencies charged with discharging benefits to Native Americans?

The CHAIRMAN. No.

Mr. FIELD. There is, in the coordinating council great hope. We have established a coordinating council in Albuquerque, and then we went to Alaska. So Alaska has one now, for that region. It is comprised of senior-level officials from the BIA, from IHS, from HUD.

The CHAIRMAN. So what you are telling us is that you hope our Government would spend as much time providing benefits as they have provided recruiting services?

Mr. FIELD. Yes, sir.

The CHAIRMAN. That is fair enough, I think.

Dr. Apuna.

STATEMENT OF DR. SAMUEL APUNA, MEMBER, NATIVE AMERICAN VETERANS AFFAIRS ADVISORY COMMITTEE, MILILANI, HI

Dr. APUNA. Mr. Chairman and members of the committee, Aloha. Thank you for this privilege to discuss some of the problems confronting the Native Hawaiian veterans. I am Samuel "Kaumuela" Apuna, presently serving on the faculty of the School of Public Health, University of Hawaii at Manoa.

I will summarize my written statement which has been submitted, and with your permission will be slightly amended.

The CHAIRMAN. Your full statement will be made part of the record.

Dr. APUNA. I would first like to thank the members of this committee who were instrumental in establishing the four VA clinics in Hawaii and one in Guam. For the first time, many veterans who live on the neighboring Hawaiian Islands and who are gun-shy of flying to the clinic on Oahu now have access to uninterrupted medical and psychiatric services.

As a preface to my presentation, let me say that there is no information available to as to how many Native Hawaiian veterans there are in Hawaii. The Department of Veterans Affairs includes Native Hawaiians in a classification entitled "Asiatic Pacific Islanders" which includes eight other major ethnic races. No one has ever surveyed or identified the number of Native Hawaiian veterans in Hawaii. An important question which should be kept in mind during today's hearing is "how can strategic planning be done by VA when no one knows the numbers of Native Hawaiian veterans, their health status, or the island location?"

VA reportedly identifies Native Hawaiian veterans by zip codes. If only one action could result from Senate Bill 13, it should be a provision to provide for the identification of Native Hawaiian veterans and the authentication of their health status.

PTSD affecting the veterans from Hawaii and other Pacific islands is appropriately covered by the final report of the Advisory Committee to VA on Native American veterans. Dr. Roger S. Hamada, at a Senate committee hearing in July 1988, expounded on the magnified effects of PTSD on the oriental and polynesian servicemen and women who fought in Korea and Vietnam.

Because our skin tone and physical features are like those of the Koreans and Vietnamese, Native Hawaiians were at times mistaken for the enemy, or even taunted by our fellow soldiers. This added stress compounded the effects of PTSD on the Native Hawaiian veterans, as well as other Native American veterans, who exhibit similar physical characteristics.

There is now emerging a group of Native American veterans who are currently retiring from the National Guard of the United States Reserve Forces in Hawaii. Members of this group have harbored suppressed emotions since returning from combat in Vietnam. They suffered the same indignation as other servicemen from Hawaii, but with an additional traumatic experience which compounded their post-traumatic stress syndrome.

The Hawaiian National Guardsmen and members of the 100th Army Reserve Battalion all volunteered with the understanding that they would train together, and if activated, would fight together, as a unit. In June 1968, the 29th Hawaii National Guard Brigade was activated and joined by the 100th Battalion, a Reserve unit.

Because of heavy casualties experienced by the Army units in Vietnam during the 1968 Tet Offensive, it was imperative that individual replacements be expedited. The closest replacements to Vietnam were in Hawaii, and thus the Hawaii National Guard unit was stripped of its soldiers who were hurriedly shipped to Vietnam as individual replacements.

The Native Hawaiian is customarily a team players. They live and work in an "Ohana" or family concept. Their family can constitute blood relatives to an extended family of friends. This trau-

matic displacement from a state of family comradeship and being immediately supplanted into an alien American unit as an individual happened during the most intensive fighting in Vietnam.

Individual cases of severe manifestation of PTSD are appearing in this group, with an unusually high rate of divorces and antisocial disorders. The dilemma of this situation is that we don't know the number, the magnitude of the problem, nor the severity of the effects of this compounded PTSD on these Native Hawaiian veterans.

Senate Bill 13 provides for the study of PTSD affecting Native American veterans. This provision is needed and the funding the proposed PTSD studies of Native American veterans should remain intact. Further, VA should be instructed to ensure that a part of the PTSD study address this problem affecting the Native Hawaiian National Guard and Reserve veterans from Hawaii.

The second issue I wish to address is the low utilization of VA services by Native Hawaiians. Medical records at the VA clinic in Honolulu indicates a very low percentage of Native Hawaiians utilizing that facility.

During a recent exchange of information between the representatives of the American Indian, Alaskan Indian and the Native Hawaiian veterans, all agreed that there are some similarities between the Native Americans in their customs, traditions, character traits, and use of traditional healing methods.

One of these characteristics is the way in which we deal with services being rendered or offered by outsiders. All agree that Native Americans are proud people, who will not beg or seek assistance of any type from unfamiliar sources. Like other Native Americans, the Native Hawaiian is reluctant to visit the VA clinics or even other health facilities because of cultural differences.

Opening a clinic and hanging out the shingle does not constitute providing health care service for a Native Hawaiian veteran. VA use of the word "outreach" is a misnomer, since VA clinics in Hawaii are inadequately staffed to provide proper outreach, nor do they have adequate personnel who know the Hawaiians, and can reach the Native Hawaiian veterans.

VA, however, should not be singled out and solely criticized for the lack of local Hawaiian health practitioners. The problem lies in the lack of qualified educated Native Hawaiians in the health and social services field.

While staffing the four new clinics, VA did advertise for the employment of local talent. Finding none, they had to expand their recruitment to the west coast.

This predicament will not be resolved in the foreseeable future, as the education cycle requires time.

Late yesterday afternoon at a meeting with Mr. Allen Clark, Assistant Secretary for Veterans, Mr. Clark made clear his action plan and intent to include Native American representation to the recently approved Council for Native American Veterans.

Therefore, I wish to amend my original statement and withdraw my support for section 602 of S. 13, which extends the Advisory Committee. The VA Council for Native Americans, as planned, would adequate fill the gap left by the Advisory Committee, and eliminate redundancy and duplication.

In summary, I recommend that identifying the veterans who are affected by PTSD and providing them with proper services should be paramount above all other items on the VA's priority list. On this priority list, the Native Hawaiian veterans survey should be at the top.

This means surveying and identifying the Native Hawaiian veterans by location, and authenticating their health status. Secondly, developing a meaningful outreach program within the VA health system, that is staffed with local professionals. This would require training of Native American veterans as outreach workers.

Lastly, promoting Native Hawaiian veterans as students in entering the health fields, with their specialties focusing on addressing the future services of Native American veterans.

I wish to again thank you for this opportunity to address the select committee. Mr. Chairman and members of the committee, Aloha.

[Prepared statement of Dr. Apuna appears in appendix.]

The CHAIRMAN. Thank you very much, Dr. Apuna. You just reminded me of something that we experienced in World War II. As a matter of policy, the regiment in which I served, made up of Japanese Americans, was not sent to the Pacific Theater, for obvious reasons. We did all of our service in Europe.

However, we had a larger number of men of Japanese ancestry who served in the Pacific as interpreters, intelligence officers, and so on. So you don't hear much about them.

But the record shows that many of them were wounded and killed, not by the enemy, but by Allied forces, because, well, they looked like the enemy. I can imagine how in Vietnam, you would look like a VC. So I can understand when you start getting shot from both sides. It has happened in history and I suppose it will continue to do so.

As such, although I am not a physician or psychiatrist, I can see the possibility of unique stress problems coming about as a result of these very unique physical features of Asians and Polynesians, and Native American Indians. I would hope, as you have indicated, that the Congress will be sensitive to this special problem, and set aside this woefully small amount to study this problem.

On the matter of data collection, is there any effort being made at this time, either on the state level, or an organizational level?

Dr. APUNA. The Office of Hawaiian Affairs is conducting a survey of Native Hawaiians. However, they are only identifying the heads of households. If they are an individual, that is a veteran, that is the only survey that is being conducted. However, that survey is rather—it is being conducted not in a scientific method. It is just trying to collect data on the people who will come forward and give their name and information. There is no scientific survey or accurate counting.

The CHAIRMAN. Do you have an approximate number?

Dr. APUNA. The only numbers we can get is that there are 110,000 veterans in Hawaii. If we extrapolate, as the Veterans Administration does, 19 percent should be Hawaiians.

The CHAIRMAN. The Hawaiians, I suppose, will have special difficulty, because more than any other ethnic group, they have married outside their ethnic group.

Dr. APUNA. That's correct.

The CHAIRMAN. In fact, in my regiment there were literally hundreds of Japanese-Hawaiian Americans. I suppose it is up to them to tell the census taker that they are either Asian, or Polynesian.

We will do whatever we can to assist you in the data collection. I have always supported that, because without information, one cannot pursue solutions. That is what we are trying to do, and your testimony has been extremely helpful. Like the other witnesses, if I may I would like to submit questions for your consideration and response.

Dr. APUNA. I would be very happy to respond, sir.

[Material attached to Dr. Apuna's prepared statement.]

The CHAIRMAN. May I assure one and all that this will not be the only hearing on veterans. This is the first, and from this we hope to get the scope of the problem, then we will begin to zero in on the specifics, such as employment, housing, and health care. So your assistance this morning has been deeply appreciated, let me assure you.

With that, thank you all very much, and this hearing will be adjourned.

[Whereupon, at 12:14 p.m., the committee was adjourned, to reconvene at the call of the Chair.]

APPENDIX

Additional Material Submitted for the Record

STATEMENT OF SENATOR JOHN McCAIN
HEARING ON NATIVE AMERICAN VETERANS
SELECT COMMITTEE ON INDIAN AFFAIRS
NOVEMBER 14, 1989

Mr. Chairman, I thank you and commend you for convening today's oversight hearing on the subject of Native American Veterans.

Each of us meets with Indian veterans in our home states, and each of us tries to provide assistance to them on specific issues at their request. What today's hearing will provide, however, is a systematic review of issues facing Indian veterans and a report from the agencies on how they are addressing those issues.

By the testimony we will hear today, we will know better whether a problem faced by an Indian veteran is his alone, or represents a problem that is widely shared.

Just last week I received a letter from a 69-year old Army veteran who is a White Mountain Apache living in Cibicue, Arizona, whose problems may be illustrative.

In his letter, this veteran said that the Veterans' Administration told him his health problem needed to be "service related" in order to provide his assistance, so he wrote for his medical records. The VA replied that his records were apparently destroyed in a fire and could not be reconstructed. He went on:

"My question," he said, "is how does a veteran prove he has a service related disability when the records, which would tend to show such, were in the control of the government and since have either been lost or destroyed?" He continues: "This situation would be hard enough for a healthy vet, but in situations such as mine, where the vet lives in an isolated community (VA rep comes once a month), is elderly, has difficulty communicating, dealing with the Veterans' Administration becomes almost impossible."

This Indian veteran also informed me that he understands that some money may be due him from his GI insurance, but that he has been unable to learn any more than that. He says, "The problem is that every time I try to explain to a VA representative, either they don't understand me or they tell me that I have to talk with someone else."

I recognize, Mr. Chairman, that every large organization may have among its employees some who are not as helpful as they should be. But I have quoted from this veteran's letter because I think it identifies some problems -- such as remoteness of location and failures in communications -- that may be faced by large numbers of other Indian veterans.

This we will learn as we hear from tribal representatives on the first few panels.

We will also learn of the steps that the VA is taking to meet the special needs of Native American veterans. I have great respect for Secretary Derwinski and the leadership he is giving to many issues, and I am looking forward to the department's testimony as well.

Thank you, Mr. Chairman.

STATEMENT OF SENATOR FRANK H. MURKOWSKI
HEARING ON NATIVE AMERICAN VETERANS
SELECT COMMITTEE ON INDIAN AFFAIRS
NOVEMBER 14, 1989

Mr. Chairman, I think it is good that you determined to convene this hearing of the Select Committee on issues affecting Native American veterans and the efforts of the Department of Veterans Affairs and other agencies to address those issues.

As the ranking member of the Veterans Affairs Committee, I have become increasingly aware of the special needs that exist among Native American veterans, and by holding this hearing you provide members of the Select Committee an opportunity for its members to obtain additional information on the issues.

A bill which the Veterans Affairs Committee reported and the Senate passed this session includes several provisions which are specifically related to Native American veterans, and you will hear more about them today. They include a reauthorization of the VA Advisory Committee on Native American Veterans, a requirement that an Assistant Secretary take responsibility minority issues, including Native veteran issues, and provisions for outreach to veterans with Post Traumatic Stress Disorders, and to meet Native Veteran housing needs.

Since the bill is now subject of a Senate-House conference, I am unable to say what the final form of these provisions will

be, but, by inserting these provisions, the Veterans' Affairs Committee was undertaking to be responsive to the concerns it has heard expressed.

Among Alaska Natives, as with other Native Americans, it is clear that there is a continuing need for information about VA benefits and programs. Accordingly, I am looking forward to the the Department's testimony with regard to outreach efforts that are taking place under the leadership of Secretary Derwinski.

Thank you, Mr. Chairman.

TESTIMONY OF THE NAVAJO NATION
before the
Senate Select Committee on Indian Affairs
Washington, D.C.
November 14, 1989

Mr. Chairman and Honorable Committee Members: I am Irving Billy, Interim Vice Chairman of the Navajo Tribal Council of the Navajo Nation. I am accompanied by Raymond D. Morris, Executive Director of Office of Navajo Veterans Affairs.

On behalf of the Navajo Nation veterans, I am grateful for the opportunity to appear and testify before you today.

Navajo veterans represent a special group of American citizens who have served the United States in foreign wars and in peacetime. Today, there are approximately 16,022 living Navajo veterans, registered with our office, who have answered the call of duty during World Wars I & II, the Korean War, the Vietnam Conflict and in peacetime. Even today, Navajo men and women continue to serve honorably in the United States Armed Forces.

The United States and Navajo Nation must not and cannot ever forget the Navajo Code Talkers of World War II. The Navajo Code Talkers used the Navajo language in code form to enable the United States Armed Forces in the pacific to communicate vital military information which resulted in a major military victory for the United States.

Our Navajo veterans have not received the recognition they rightfully earned. Moreover, our veterans have been forgotten and have not received earned benefits despite the sacrifices they made for the United States of America. I, like many other Navajos, have brothers, uncles and relatives who have served in the various branches of the Armed Forces of the United States and who are now in need of veterans benefits and services. We are here today to call your attention to the many needs of our veterans and to seek your support and consideration in making certain legislative changes and providing funding in veteran benefits and programs.

Navajo veterans require housing assistance in the form of grants. Housing assistance for our veterans on the Navajo reservation is necessitated by several factors:

1. Income is low due to lack of job opportunities on the reservation. Among our veterans the umemployment rate is 42%. The overall Navajo unemployment rate is currently at 38.6%;

2. Lack of community infrastructure, such as roads, electricity, and water which prohibit institutional lenders to consider home loans to Navajo reservation residents; and

3. Lack of sufficient Navajo Nation leasehold interests offering loan security to lending institutions for home loans.

The Office of Navajo Veterans Affairs has identified, through applications received, an urgent need for Navajo veterans housing assistance. The immediate housing

needs include 2,743 complete homes, and 1,368 projects requiring renovation or additions to existing homes.

We have appropriated some money, from our general funds, to match state appropriations for housing assistance to our veterans. The states require a 50/50 matching. This is a start but the Nation does not have sufficient funds to match state appropriations for constructing these homes. We need the assistance of the federal government by making housing assistance grants available as matching funds to state appropriations to assist us in Veterans home construction ..

Navajo veterans who have adequate income need the Veterans Administration Direct Home Loan Program. Banks and private lending institutions are reluctant to make loans to Navajos residing on the reservation; this is because our trust lands cannot be offered as loan security to lending institutions. Navajo veterans are unable to secure home mortgage loans under the existing Veterans Administration guaranteed loan program. The Veterans Administration needs to implement a direct home loan program to meet the needs of our veterans.

Many Navajo veterans, have not utilized their earned educational benefits. Our veterans have underutilized educational benefits for various reasons:

1. There is lack of educational and vocational institutions located on or near the reservation.

2. Veterans first provide adequate homes and other basic necessities for their families. Thus, the value of continuing education becomes secondary primarily due to the fact that many veterans are the wage earners for the family and extended family.

3. Often veterans can only secure low paying or seasonal jobs on or near the reservation which is inadequate to support their families plus attend educational institutions.

4. Some of our older veterans lack the necessary educational basics to attend educational and vocational institutions.

In this regard, Congress and the Veterans Administration must make legislative changes to extend the period of time to utilize educational benefits for our veterans. For our less educated veterans educational opportunities such as vocational trades in areas of carpentry, welding, printing, electricity, plumbing and so forth, need to be made available. Such an undertaking requires legislative changes which extend or amend the period of time to utilize educational benefits and requires funding under the Veterans Administration for training supplies, tuition and stipends for veterans to attend various trade schools.

Navajo veterans require substance abuse treatment and counseling programs located on or near the reservation. Many of our veterans are afflicted with alcoholism and post traumatic stress disorder (PTSD) upon return from military service. Substance abuse treatment centers and programs for our veterans are few and far from the reservation. In addition, the Indian Health Service (IHS) has an overload in meeting the counseling needs of veterans suffering from PTSD or other military service related disorders. Funding and professional staff to provide initial counseling and referrals to on and off reservation treatment centers are direly

needed. We recommend that professional and medical staff be funded under the existing IHS facilities on or near the reservation specifically for our veterans.

Navajo veterans require the acceptance of Native American healing practices by the United States Veterans Administration as an acceptable form of medical treatment. Navajo traditional healing practices are performed over our men and women entering the military service and returning as warriors, and in healing or continuing treatment of Navajo men or women who served in the Armed Forces of the United States. Further, traditonal healing practices are often needed in treating our veterans who suffer physically or mentally from a direct or indirect result of serving in the military. All these traditional healing and counseling practices are performed by Navajo practitioners.

We request that the United States Congress accept Native American traditional healing as a part of the acceptable and allowable medical treatment under the Veterans Administration's program. Acceptance of this needed treatment process conducted by certified Navajo medicinemen will allow our veterans to receive traditional healing treatments and assist the veteran in paying for these healing ceremonies which is otherwise paid for by the veteran.

The Navajo Nation needs veterans cemeteries throughout the reservation to bury its veterans. Presently, we have one central veterans cemetery, near Window Rock, Arizona, which is now closed because there is no more space available to bury anymore veterans. Like all Americans, we desire to pay due respect and honor to our deceased veterans.

We are presently planning for five (5) cemeteries, one in each Agency, and one central cemetery in Fort Defiance, Arizona, near the Capitol of our Nation. In order to construct and landscape appropriate cemetery sites, we request the support of this Committee to recommend and support allocating sufficient funding.

In closing, I respectfully request this Committee to recommend to Congress the introduction of legislation that reflects the needs and concerns of Indian veterans. In addition, we request that a Navajo representative be selected to serve on the Veterans Administration Advisory Committee. Such representation is essential in addressing the concerns and needs directly affecting our veterans, and all other Native American veterans throughout this country.

Mr. Chairman and Honorable Committee members, I appreciate your time and attention. If you have any questions, I will be glad to answer them at this time. Thank you.

OPENING STATEMENT

I am Commander Edwin Chappabitty, Jr., a Family Practice physician and Chief of Staff at the Lawton Indian Hospital in Southwest Oklahoma. I am a member of the Comanche Tribe and a Chiricahua Apache descendant. As a Regular Army officer, I served on active duty from 1967 to 1972. In Vietnam I was an artillery forward observer in an armored calvary squardon and later, an artillery liaison officer with a tank ba talion. I graduated from the University of Colorado School of Medicine with the assistance of the GI Bill. My home was purchased through the Veterans Administration Home Loan Program. I am on leave today from the Indian Health Service and represent the Comanche Nation Chairman, Mr. Kenneth Saupitty.

Military service veterans occupy a place of respect and honor throughout Indian Country. Traditional Native American celebrations and pow-wows begin and end with veteran songs, honoring all servicemen and women for their dedication, devotion and sacrifice. The American flag is proudly carried or raised at these events by representatives of the veteran community. Should an Eagle feather inadvertently fall from a dancers' regelia, the dancing stops while a veteran is selected to recover and return it to its owner.

Traditional Native American veterans organizations and warrior societies abound throughout Indian Country. Such organizations as the Navajo Code Talkers, the Comanche Indian Veterans Association, the Kiowa Blackleggings, and the Vietnam Era Veterans Inter-tribal Association are but a few. War mother societies participate along with their veterans. Who is not touched by the sight of an aged war mother's tears as she sings a veteran song in honor of a son lost in battle decades ago. Her loss is acknowledged by special war mother songs.

For the past six and a half years, I have had the honor of providing direct medical care to the Native Americans of Southwest Oklahoma, including many veterans and their families. In doing so, I have obtained a detail medical and social history of each patient. The issue of veterans status arises as it may offer a possible alternative to Indian Health Service care, as well as recognizing specific veteran issues such as Agent Orange exposure, post traumatic stress syndrome or Prison of War status.

In the area of veterans educational benefits, I find most Native American veterans do not fully use these benefits. Most veterans reflect junior enlisted grades, typically serving one or two terms of enlistment. The veteran who completes baccalurate level schooling are usually those who have some college work prior to enlistment. Many veterans elect to enter trade schools, typically finishing these in months to a few years. Remaining periods of eligibility tend not to be used. Many veterans are aware there are expiration dates on educational benefits but commonly do not know the actual length of eligibility. Veterans typically return home, seek employment, marry and start families in the community they left due to strong family and community ties. Few veterans seem receptive to relocate to other states for employment opportunities.

In regards to Housing issues, most veterans I know do not use the Veterans Administration Home loans. When ask why, one veteran replied, "when I got out of the Army, I didn't have a job, so I didn't qualify for a VA loan. It didn't matter if the rates were low or had no down payment". Many veterans simply returned to their parents home or rented homes nearby. In the past decade, the emergance of Tribal Housing Authorities have provided an attractive alternative in finding adequate housing. Many veterans receive modern, low cost housing on Indian Trust land through these programs with monthly payments based upon income and family size. The veteran may also find tribal housing authorities more lienant in regards to late or delinquent payments.

In the health field, I not many Native American veterans rely almost solely on the Indian Health Service. Indian Health Service and

various tribal health authorities operate a comprehensive line of health stations, clinics, and hospitals throughout Indian Country. Many veterans do not posses health insurance plans. Veteran Administration clinics and hospitals may be located far from Native American population centers. A dietary employee in my hospital, a former prisoner of war who parachuted from a burning B-17 into Germany, stated, "I only went to the VA Hospital in Oklahoma City a few times. It was almost ninety miles one way and the lines were longer than here. I only got to see the doctor for a few minutes." When pressed further he stated, "this is my hospital, I get all my care here, my family too." Recently, a VA clinic opened in our city, but few eligible veterans seem to have even registered there. They often state, the "paperwork was to much of a hassle."

In summary, there exist a need to identify and inform Native American veterans of deserved benefits. Cooperation between tribal authorities, veterans organizations and U. S. government agencies should be encouraged. Within mission requirements, the Indian Health Service and the Veterans Administration should cooperate in identifying and meeting specific Native American health issues.

STATEMENT OF JERRY HANEY
PRINCIPAL CHIEF OF SEMINOLE NATION OF OKLAHOMA
AND NATIONAL COMMANDER VIETNAM ERA VETERANS
INTERTRIBAL ASSOCIATION
OVERSIGHT HEARING BEFORE THE SENATE SELECT COMMITTEE
ON INDIAN AFFAIRS ON INDIAN VETERANS
November 14, 1989

Mr. Chairman and members of the Committee, it is extremely important to us to talk to you today on Indian veterans issues. Mr. Chairman, we recognize you as a distinguished war veteran, Chairman of the Senate Select Committee on Indian Affairs and we deeply appreciate the efforts you and your Committee have made concerning the native American veterans.

We would like to thank you for calling for these oversight hearings concerning native American veterans issues, and allowing us the opportunity to utilize this format to provide you with our testimony on behalf of the Vietnam Era Veterans Intertribal Association

My name is Jerry Haney, Principal Chief of the Seminole Nation of Oklahoma and National Commander for the Vietnam Era Veterans Intertribal Association. Accompanying me today is our Executive Director Mr. Matthew Kauley.

As you know, the Vietnam Era Veterans Intertribal Association was founded in 1981 to promote and improve the life style of the native American veterans. Our organization has grown to a membership in excess of 1200 members and continues to grow on a daily basis. We feel this drastic growth is attributed to our ability to recognize how important our native American cultural beliefs are to our target population group and that our sensitivity to the native American culture is a binding force that allows for all native American veterans an opportunity to participate.

It has been our experience that native American veterans are reluctant to approach the Veterans Administration for services or assistance due to the Veterans Administration's lack of cultural sensitivity of the native Americans veteran needs. In addition, these cultural differences also prohibits native American veterans from participating in other national veterans organizations. Therefore, we have identified the problem: How can the V.A. meet the needs of the native American veteran without recognizing the cultural differences of this target population group?

Mr. Chairman, I would like to inform you and the Committee on how we reached this conclusion.

In 1987, The Vietnam Era Veterans Intertribal Association developed a reorganizational initiative to allow for improved communication among the various chapters of the Association. In 1988, the proposed model was approved by the membership during the 7th Annual Conference and Pow-Wow held in Pine Ridge, South Dakota. In 1988 the Association developed the newsletter entitled "Red Smoke" (see Attachment 1) to serve as a cultural information publication and recruiting tool to serve the native American veteran. In addition, the Association opened a national office for the purpose of coordinating and disbursing information to native American veterans. The VEVITA national office is located in Shawnee, Oklahoma and the office maintains space for the VFW, VVA service representatives and VA outreach counselor. In May 1989 the Association participated in a national conference entitled "Encircling Our Forgotten", a mental health issues conference for the emotionally disturbed North American Indian child and adolescent. The title of our presentation was "The Vietnam

Post-Traumatic Stress Disorder and the Native American Family" (see attachment 2).

In June 1989 the VEVITA Association held the 8th Annual National Veterans Conference and Pow-Wow entitled Native American Veterans; Have We Been Forgotten" (see attachment 3) in which over 4000 veterans, friends and relatives participated.

On October 4, 1989, the National Congress of American Indians called upon the VEVITA to develop a ten point plan to address veterans issues (see attachment 4) The VEVITA is a non-profit entity that depends on donations and in-[illegible] contributions for support. The Organization does not receive any federal funds.

VEVITA was instrumental in the production of the following videos: "Shadow of the Warrior," " Warriors" produced by Deb. Hallwork, and "Spirit of the Warrior" produced by Dr. David Rico.

Now in contrast I would like to show you, Mr. Chairman, what the V.A. has done starting in 1983. In 1983 the V.A. formed a national working group on Indian Vietnam veterans. In December of 1983, the working group decided to initiate a national survey of American Indian veterans for the purpose of starting the data-collecting process.

In 1986 the Consolidated Omnibus Reconciliation Act of 1986, Public Law 99-272, Section 19032 required the Administrator of Veterans Affairs to establish a V.A. Advisory Committee on Native American Veterans.

In 1988 the V.A. Advisory Committee on Native American Veterans (see Attachment 5) submitted a final report to the Administrator of the Veterans Administration. The Committee reported two major findings: the lack of data on native American veterans and Native American veterans underutilized V.A. benefits and services.

In May 1989, Edward J. Derwinski, Secretary, Department of Veterans Affairs approved the establishment of the Native American Veterans Advisory Committee and Coordinating Council.

In conclusion, Mr. Chairman, Native American veternas have always shared a bonding between their fellow brothers and sisters veterans. The native American veterans need to participate in the services of the V.A. However, we feel that the V.A. is not equipped to meet the needs of the native American veteran. Mr. Chairman, all we ask is that you oversee the Executive Branch and make them do their jobs. Here is what we propose:

1. Native American data base
2. National veterans office to serve as national clearinghouse
3. National Service Officers Training School
4. Cross cultural training for non-native American VA personnel
5. Improved outreach effort by V.A., Vet Center to be located within native American communities.
6. V.A. provide culturally sensitive information
7. Native American desk within the V.A. and additional native American staff
8. V.A. to address, PTSD, V.A. home loan for native Americans, Job development and placement, small business loan, homeless and incarcerated native American veterans, mental health issues, and employment opportunities.

- STATEMENT OF JERRY HAVEY -
ATTACHMENT 1

VOLUME 2 NO. 1 A Hot LZ for Native American Veterans News April 1989

RED SMOKE INTER-TRIBAL NEWS

FREE OUR POWs/MIAs

VIETNAM ERA VETERANS INTER-TRIBAL ASSOCIATION

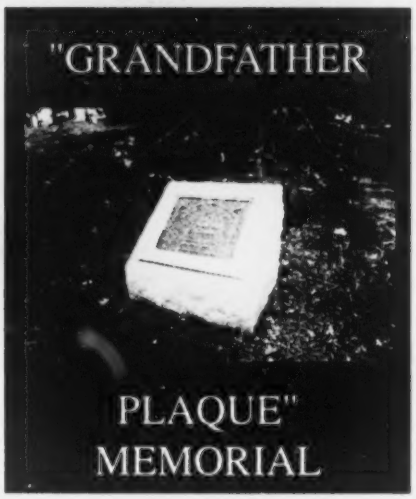
8 th ANNUAL NATIONAL VETERAN CONFERENCE & POW-WOW

Shawnee, Oklahoma
Potawatomi Tribal Grounds & Holiday Holidome
June 8-11, 1989

Theme: Native American Veterans; Have we been forgotten?

The Vietnam Era Veterans Inter-Tribal Association (VEVITA) 8th Annual National Veterans Conference & Pow-Wow focuses on the need to improve the outreach efforts of the Veteran Administration and National Veteran Service organization's while establishing a natioanl dialog of interaction between various public & private organizations, such as the Department of Housing and Urban Development (HUD), Tribal Governments, Tribal Housing Authorities, Bureau of Indian Affair (BIA), Indian Health Service (IHS), U,S. Department of Commerce Bureau of the Census and other National non-profit entities such as private foundation that administer funds for Native Amercian Veterans. This format will allowing for the exchange of information and ideals for improving the communication network between the various organizations and the Native American Veterans.

See page 2 8th Annual



The Eastern Regional Command of the Vietnam Era Veterans Inter-Tribal Association (VEVITA) hosted the second Anniversary of the installation of the "Grandfather Plaque" which was placed in Arlington National Cemetery.

In This Issue

Southwest Region-Arizona VEVITA
8th Annual Registration Form
Golf Tournament
Advertisment
Mail Call
Legislative Update

NAM

8th Annual--con't

Various Government & National Veterans Service organization will be in attendance including: the Veteran Administration, VA Indian working Group, National Vietnam Veterans Coalition (NVVC), Vietnam Veterans of America (VVA) Disabled American Veterans (DAV), Brotherhood Rally of Veterans Organization (BRAVO), American Ethnic Veterans of Vietnam,(AEVV) Inc., The Last Patrol and other veterans organizations.

The Conference will address a number of topics including: PTSD and the Traditional Healer, VA Home Loan Program on Trust and Restricted Lands, Homeless Veterans, Mental Health Issues, Native American Veterans as a positive role model,, Veterans Business Connection, Legislative Updates, Natural Resources (Water Rights) and showcase other new and innovative programs that are culturally sensitive to the native american veteran. In addition, VEVITA will also Host the NVVC Leadership Breakfast. The Conference will allow Veterans an opportunity to interact with Veterans Administration personnel, National Service Organization Representatives and fellow Veterans of various races and ethnic backgrounds from all walks of life blended with a Native American atomsphere.

The evening festivities will be centered around the National Vietnam Veterans Pow-Wow. The Dance Grounds will be encirled by a National Veterans Encampment. This encampment allows for a full blend of togetherness and peer counseling in a total family environment. No Drug or alcohol will be allowed on the grounds. A number of Pow-Wow Activities have been scheduled, as follows: Nightly Grand Entries, Dance Contest, Special POW-MIA Ceremony, National VEVITA Princess Contest and special veterans honor songs and dancing. This year the VEVITA has selected Mr. Matthew Reed, (Kickapoo/Sac & Fox) Tropical Lightning 25th Infantry Division as the National Honoree. A Special invitation to the men of the 45th Infantry Division-**THUNDERBIRDS.**

Recreational Activities include: Golf Scramble and Tournament, Rifle Shoot, Archery Contest, High Stakes Indian Bingo, Horse shoe contest, Parade, National High School Rodeo Finals and the Shawnee Santa Fe Days. The Conference and Pow-Wow is open to anyone who wishes to attend and participate in this important and unique National event.

The Conference & Pow-Wow will be held at the Potawatomi Tribal Grounds, Shawnee, Oklahoma. National encampment and RV Parking available at the Potawatomi Tribal Pow-Wow Grounds. Room reservations can be made at the Holiday Holidome by calling area code (405) 275-4404. Room rates for the conference is a flat $28 plus tax. Booth Space is available by contacting Mary Ferrell at (405) 275-3121 for crafts and food vendors

Additional Information may be obtained by contacting the VEVITA National office located at 624 N. Broadway, Shawnee, Oklahoma 74801 or calling (405) 275-2525. See you in Shawnee. ■

Service Representatives will be on site at the conference to serve your needs or answer your questions concerning VA benefits

ARIZONA VEVITA COLOR GUARD

SOUTHWEST REGIONAL

Tom Amiotte,

STANDING TALL

Tom Amiotte, Matthew Kauley &Ed Yava

POST OLD GLORY AT AAIP/NIH/IHS BIOMEDICAL SYMPOSIUM POW-WOW

On April 24, 1989 the Arizona Vietnam Era Veterans Inter-Tribal Association (VEVITA) SOUTHWEST REGIONAL COMMAND served as the color guard for the Association of American Indian Physicians (AAIP), Institues of Health (NIH) and the Indian Health Service (IHS) Symposium Pow-wow on Biomedical Careers for American Indians and Alaska Natives entitled "Exploring Tomorrow's Frontiers"

The pow-wow was held in honor of the first biomedical conference jointly hosted by the NIH and the IHS. The conference was designed to identify new opportunities in research and the biomedical sciences for American Indian and Alaska Native Students. In addition to the Variety of institutional exhibits and various research training programs available on site for the students the symposium also allowed for the interaction of the Native American culture in the form of a pow-wow.

The AAIP was asked to sponsor the pow-wow and called upon the following staff to assist in this unique event. The head staff for the pow wow included, Mr. Sammy "Tonkei" White, Master of Ceremonies, Mr. Terry Lavary, HeadMan Dancer, Ms. Cherie Thomas, Head Lady Dancer, Mr. Elton Yellowfish, Head Singer and Mr. Ed Yava, Arena Director/ VEVITA member also our own Arizona VEVITA served as the Color Guard for the Grand Entry. The evening program included the gourd dance and was followed by the grand entry, social and contest dancing. The pow-wow was attended by over a crowd of 400 individuals. The Grand Entry was the highlite of the Pow-wow. The color guard was lead by Mr. Tom Amiotte, President, Mr. Ed Yava, Arizona VEVITA member and Mr. Matthew Kauley, VEVITA Executive Director. The Arizona VEVITA is currenlty in the process of raising funds to support it's members and other Veterans who would like to attend the 8th Annual Vietnam Era Veterans Inter-Tribal Association National Veterans Conference & Pow Wow to be held at the Potawatomi Tribal Grounds & the Holiday Holidome, Shawnee, Oklahoma, june 8-11,1989. Mr. Amiotte is trying to identify Vietnam Era Veterans in Arizona, New Mexico and Southern California.

The Arizona VEVITA is looking to interact with other Veterans organization who would like to donate funds or be a part of the planning process to split the cost for a bus charter to the VEVITA National Conference. In addition, the Arizona VEVITA is seeking assistance in obtaining badly needed office space to perform outreach assistance and establish a Regional Command Headquarters. If you can help, please contact Mr. Amiotte■

Vietnam Era Veterans Inter-Tribal Association
8th Annual National Veterans Conference & Pow-Wow
Fire Lake Golf Course
Pottawatomi Tribal Grounds
Shawnee, Oklahoma
June 8-11, 1989

GOLF TOURNAMENT

Golf--Golf--Golf--Golf--Golf--Golf--Golf--Golf--Golf--Golf--Golf--Golf--Golf--Golf--Golf

Coordinated by:
The Oklahoma City Indian Golf Club

Vincent Knight, President Pat Rhoades, Sec/Treasurer
Dan Amos, Vice-President Simon Mitchell, Club Tournamen

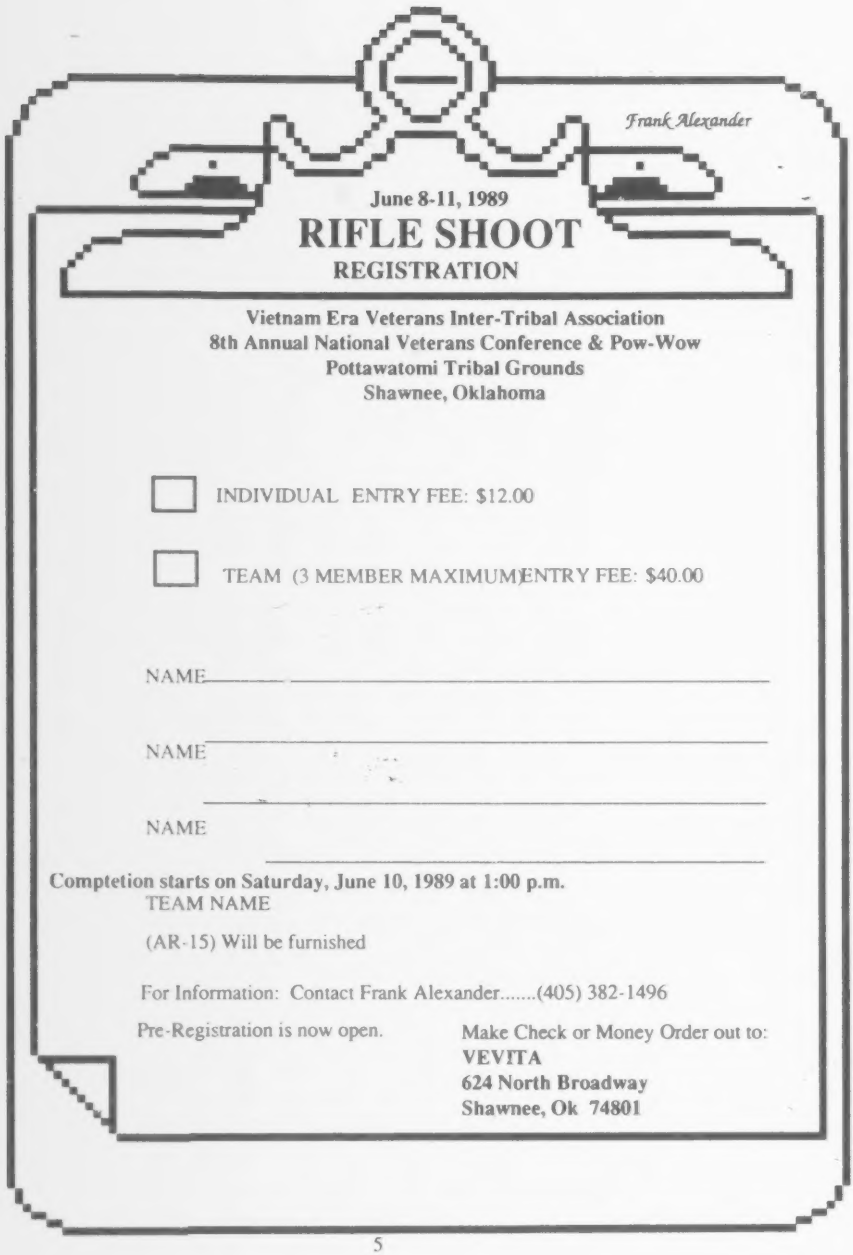
Golf Course:
Beautiful "FIRELAKE"
Firelake is located and owned by the
Pottawatomi Tribe, Shawnee, Okla

June 9, 1989 1:00 p.m. SCRAMBLE
Entry Fee $15. Pay your own green fee & cart, be there at least 1 hr before tee off

June 10, 1989 1:00 p.m. Qualifying Rounds
Entry Fee $35 Men, $30 Women

June 11, 1989 7:30 a.m. Tee Off
for additional information contact Pat Rhoades (405) 794-7844 or 732-0324 ext. 251

The Oklahoma City Indian Golf Club has been in existence for many years. It has a membership of over 60 Indian golfers, men, women and juniors. The club was established to promote the game of golf among Indian people. The club holds its annual golf tournament the last weekend in July. This years Tournament will be held on july 29-30, 1989 at the lincoln west golf course, Oklahoma City, Ok. The Vietnam Era Veterans would like to recognize and thank the Oklahoma City Indian Golf Club for coordinating the 8th Annual National Veterans Conference & Pow-Wow Golf Tournament.



June 8-11, 1989

RIFLE SHOOT

REGISTRATION

Vietnam Era Veterans Inter-Tribal Association
8th Annual National Veterans Conference & Pow-Wow
Pottawatomi Tribal Grounds
Shawnee, Oklahoma

☐ INDIVIDUAL ENTRY FEE: $12.00

☐ TEAM (3 MEMBER MAXIMUM)ENTRY FEE: $40.00

NAME_____

NAME_____

NAME_____

Comptetion starts on Saturday, June 10, 1989 at 1:00 p.m.

TEAM NAME

(AR-15) Will be furnished

For Information: Contact Frank Alexander.....(405) 382-1496

Pre-Registration is now open.

Make Check or Money Order out to:
VEVITA
624 North Broadway
Shawnee, Ok 74801

VIETNAM ERA VETERANS INTER-TRIBAL ASSOCIATION

8th ANNUAL NATIONAL VETERANS CONFERENCE

Pottawatomi Tribal Ground
Shawnee, Oklahoma
June 8-11, 1989

REGISTRATION

Name:_____

Address:_____

SS #_____ Phone No:_____

Employer:_____ Job title:_____

Race:_____ Tribe:_____

Sex:_____Date of Birth:_____Age: _____

Branc of Service:_____ Tour of Duty:_____

The Conference is open to anyone who would like to attend:

Conference Registraton fee: $25 per Individual/Family.....$_____enclosed

VEVITA/NVVC leadership Breakfast fee: $10 per Individual.....$_____enclosed
The Breakfast is scheduled for 8:00 a.m. friday morning June 9, 1989 at the Holiday Holidome

Archery Contest Fee. $7.5 per Individual.....$_____enclosed

Donations: To sponsor a Veteran to the conference $25.00.....$_____enclosed

Make Check payable to: **VEVITA**
624 N. Broadway
Shawnee, Ok
(405) 275-2525

All proceeds will be utilized to help defray the cost of this important event.

ADVERTISMENT

UNIFORMED SERVICES UNIVERSITY OF THE HEALTH SCIENCES
F. EDWARD HEBERT SCHOOL OF MEDICINE
4301 Jones Bridge Road
Bethesda, Maryland 20814-4799
NEWS RELEASE
A Career In Military Medicine

The Uniformed Services University of the Health Sciences in Bethesda, Md., is the military's own medical school. Established by an act of Congress in 1972, this joint-service school is designed to provide DoD with a cadre of career medical officers for the Army, Navy, Air Force and the U.S. Public Health Service.

The medical students are commissioned as ensigns or second lieutenants on acitve duty reserve status, and draw full pay and benefits while in school.

At graduation, students receive the M.D. degree and a promotion to captain or lieutenant, and must serve seven years to pay back the education.

Civilian applicants may be no older than 27 when they enter the medical school, applicants with military service can exceed the age limit by up to three years to age 31- based on the amount of prior service.

The University also has a graduate program leading to advanced degrees in the health sciences. For more information, contact the Office of Admissions, Attn: PAC, Uniformed Services University, 4301 Jones Bridge Rd., Bethesda, MD, 20814-4799 or call (202) 295-3101. ■

VIETNAM

OPENING DOORS TO THE WORLD

The beauty of Vietnam today!
270 color photos of the magnificent landscape of Vietnam. Siagon, The Mekong Delta, Central Highlands, Da Nang & Nha Trang, Khe Sanh & Hue, Hanoi and the North and more.

Make Check Payable to: VEVITA
I am enclosing $_____for: _____copies of
VIETNAM: Opening Doors to the World at
$17.95 each plus 1.50 postage. (19.45 total price)
Naame_____
Address_____
City/St/Zip_____

7

MAIL CALL

Dear Red Smoke:

I'am writing in hopes you may be of assistance in helping me locate a MARINE BUDDY of my husbands. His name is:

SGT. Paul Bear, (Cherokee), last known address was Henryetta, Ok or Amwatt, Vietnam 1968-1969
Would appreciate any help you could give us on this matter.

Sincerely,
Mrs. Melvin Hasty
210 S. Greenwood Ave.
Du Quoin, IL 62832

LEGISLATIVE UPDATE

S.192 A bill to require the Secretary of Veterans'affairs to provide for the conduct of a comprehensive study of the psycohological problems of Native Americans who are Vietnam veterans; to the Committee on Veterans'Affairs.

"Support for this small bill will improve our understanding and treatment of thousands of Vietnam veterans whose special psychological problems are overlooked or simply misunderstood because they happen to belong to a racial or ethnic minority"-Matsunaga ■

PARADE & INFORMATION

If your organization or group plan to be in the parade please contact the Oklahoma VEVITA at area code (405) 275-2525 and leave your information with the secretary or mail your information in.

VEVITA PRINCESS INFORMATION

If your VEVITA CHAPTER plans to sponsor a contestant in the princess contact please contact the Oklahoma VEVITA at area code (405) 275-2525 and leave your information with the secretary or mail your information in.

"REDSMOKE"™ is published quarterly by the Vietnam Era Veterans Inter-tribal Association 624 N. Broadway, Shawnee, Oklahoma 74801. Views of contributing writers do not reflect the policies of the VEVITA.

Red SMOKE

Editor
Matthew Kauley

Layout/Graphics
Matthew Kauley

"Welcome Back to the World".

COMING EVENTS

June '89

8-11	8th Annual National VEVITA Conference & Pow-Wow Shawnee, OK.

July '89

10-14	Vet Center Indian Working Group Meeting San Antonio, TX.

August '89

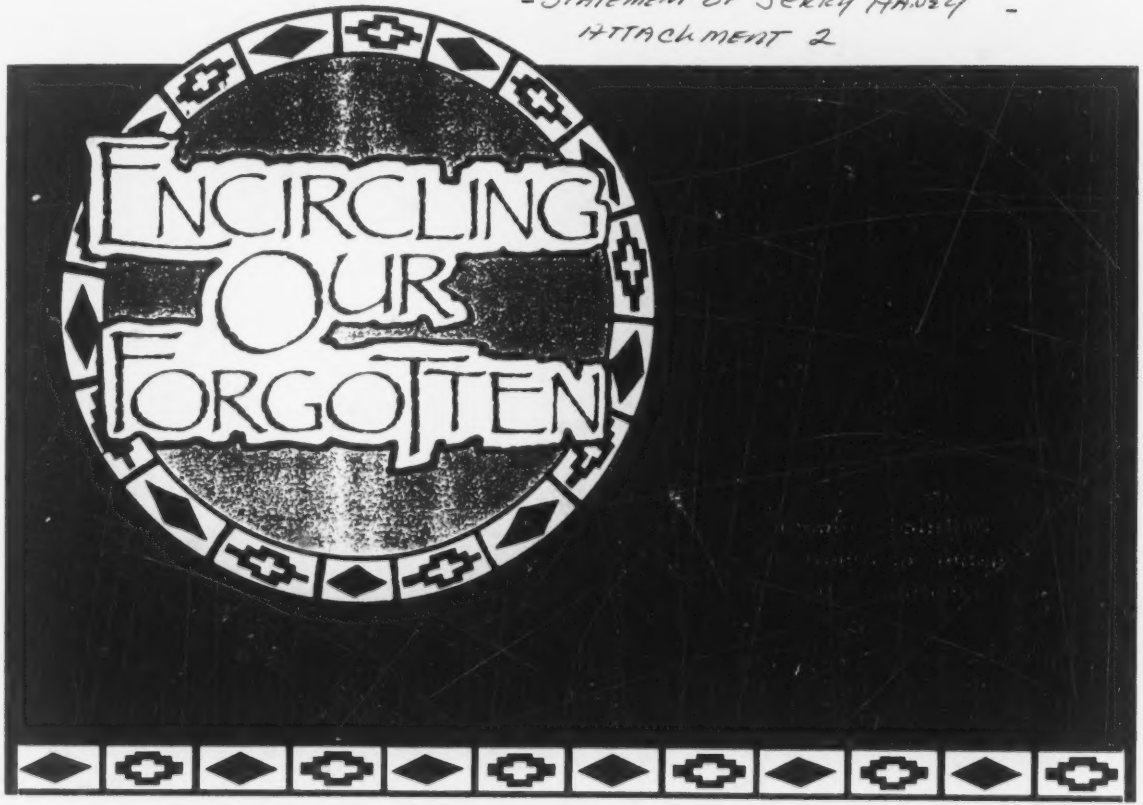
3-6	V.V.A. 4th National Convention Hyatt Regency Hotel Chicago, Illinois
8-10	Association of American Indian Physicians, 18th Annual Meeting-National Health Conference and Pow-Wow, Oklahoma City, OK. Holiday Inn-Airport West.

September '89

15-17	4th Choctaw Arrowhead Pow-Wow, Pittsburgh County, Seminole/Muskoke Nation Color Guard

Vietnam Era Veterans Inter-tribal Association
624 N. Broadway
Shawnee, Oklahoma 74801

- STATEMENT OF JERRY HANLEY -
ATTACHMENT 2



THE VIET NAM POST TRAUMA STRESS DISORDER AND THE NATIVE AMERICAN FAMILY

A panel of selected Viet Nam era veterans will participate in this panel presentation discussing *Post Trauma Stress Disorder*, which has manifested itself across the United States. This has resulted in whole families experiencing the Viet Nam war through the Veteran father, son, uncle, or spouse. The children of these PTSD veterans have emotional disorders that evolve out of this relationship. As practitioners, the familial assessment of these children may be a key factor in working with their emotional disorders.

KEYNOTES AND OTHER SPEAKERS AND PRESENTERS

Scott Nelson, M.D., Chief, Mental Health Programs, Indian Health Service, Rockville, Maryland

Jake Whitecrow, (Quapaw), President, Craw, Fish & Whitecrow & Assoc., Denver, Colorado

A representative from the Senate Select Committee on Indian Affairs

Terry Cross, M.S.W., (Seneca), Director, Northwest Indian Child Welfare Institute, Portland State University, Portland, Oregon

Marva P. Benjamin, A.C.S.W., Director, Minority Initiative, CASSP Technical Assistance Center, Georgetown University Child Development Center, Washington, D.C.

Marc Mannes, Senior Program Manager, American Indian Law Center Inc., Albuquerque, New Mexico

CONFERENCE COSTS

The cost for attending the conference, "Encircling Our Forgotten: A Conference on Mental Health Issues for the Emotionally Disturbed North American Indian Child and Adolescent," is $95 per participant. The cost includes registration fees, all conference sessions, resource materials, handouts, a luncheon, an Indian feast and a copy of the conference proceedings book. Participants are responsible for costs of lodging and meals. It is strongly suggested that you make your hotel reservation (if staying at the Sheraton Century) by May 17, 1989.

CONTINUING EDUCATION UNITS

Conference participants will receive 1.6 Continuing Education Units, which will be recorded by the University of Oklahoma. CEU's provide evidence of your personal and professional development and can be used to support job advancement.

RED EARTH '89

Red Earth '89, to be held June 2–4 in downtown Oklahoma City and across from the Sheraton Century Hotel, is the world's largest Native American celebration. Included in the festivities are a competition of the finest Native American dancers in North America, a fine arts festival featuring works by reknowned contemporary Native American artists and artisans, and a feast of Native American foods. Red Earth '89 is the result of a dream by leaders of Oklahoma's tribes, in cooperation with Oklahoma business, civic, and government leaders, to bring together the best examples of Native American culture and share it with other Americans and people from all over the world.

Red Earth '89 will begin with a parade through downtown Oklahoma City at 11:45 a.m. Friday, June 2. Indian arts and crafts exhibits will fill the streets and sidewalks adjoining the Myriad. Competitive dancing events will be held at the nearby Myriad Convention Center, where last year more than 1,100 people performed their traditional dances nightly. For further information, please contact Red Earth '89, 4917 North Portland, Oklahoma City, OK 73112; phone (405) 943-2784.

PRE-REGISTRATION FORM

Second Annual "Encircling Our Forgotten: A Conference on Mental Health Issues for the Emotionally Disturbed North American Indian Child and Adolescent"
May 31-June 1, 1989 Oklahoma City, Oklahoma

AI32-0011-901

Name _____
Last First Initial

Mailing Address _____
Street City State ZIP

Social Security Number _____

Home Phone _____ Work Phone _____
AC + number AC + number

Employer Name _____

Job Title _____

☐ White, Non-Hispanic ☐ American Indian ☐ or Alaskan Native ☐ Black Non-Hispanic ☐ Hispanic ☐ Asian or Pacific Islander ☐ Non-Resident Alien

Sex: ☐ Female ☐ Male Year of Birth: _____

Education: ☐ Grade 1-8 ☐ High School Graduate ☐ Some College ☐ Associate Degree ☐ Bachelor ☐ Graduate Degree ☐ Professional

Payment Information:

Payment Enclosed (Please check appropriate ☐ at left): $ _____

OR:

Send bill to: _____

_____

OR:

Charge to: VISA ☐ MASTERCARD ☐ CARD NUMBER: _____

_____
SIGNATURE

WHEN YOU PRE-REGISTER BY PHONE OR MAIL, YOUR OFFICIAL EXPO REGISTRATION CARD WILL BE COMPLETED FOR YOU. YOU NEED ONLY STOP BY THE EXPO REGISTRATION DESK TO SIGN IT. THANK YOU.

Please mail pre-registration form to: Continuing Education Central Registration Service
University of Oklahoma
1700 Asp Avenue
Norman, Oklahoma 73037

Or, register by phone at: Continuing Education Central Registration Service, (405) 325-2340
Toll Free Outside Oklahoma: 1-800-523-7363, Ext. 2240
Toll Free Inside Oklahoma, 1-800-522-0755

For further program information call: American Indian Institute, (405) 325-4127

CONFERENCE SPEAKERS, PRESENTERS AND WORKSHOPS

Marlene Echohawk, Ph.D. (Otoe)
Clinical Psychologist
Navajo Nation
Chinle Comprehensive Health Care Facility
Chinle, Arizona

FETAL ALCOHOL EFFECTS: WHAT ARE THE INTELLECTUAL ABILITIES OF FAE CHILDREN?

Session participants will hear discussion about the intellectual abilities of Fetal Alcohol Effects children. The physical and motor capabilities or incapabilities of these children are visually apparent, but are we selling these children short on their intellectual abilities? This presentation will include actual case histories of FAE children, their assessment and development.

Beverly Patchell, R.N., M.S. (Cherokee-Creek)
Clinical Specialist
Psychology—Mental Health Nursing
Willow View Hospital
Oklahoma City, Oklahoma

CHILD & ADOLESCENT SUICIDE

Suicide among our Native American youth is of growing concern in not only the urban settings, but also in the reservation and rural areas of the United States. Four areas will be highlighted and discussed by the presenter: (1) The patterns of development and suicidal behavior, (2) the links between personality and suicidal behavior, (3) family dynamics, and (4) assessment and approaches.

Tim Tallchief, M.Ed. (Osage)
Director
Oklahoma Foundation for the Disabled
Oklahoma City, Oklahoma

ALTERNATE FORMS OF THERAPEUTIC ACTIVITIES

The workshop will present information on alternate therapeutic activities that can be utilized by not only the emotionally disturbed individual, but also the physically and mentally handicapped. Utilizing the alternate activities such as the "ropes course" can aid in the development of leadership skills, self-esteem and problem solving.

Dolores Subia Bigfoot, Ph.D. Candidate (Caddo)
Counseling Center
University of Oklahoma
Norman, Oklahoma

TRADITIONAL PARENTING PRACTICES

Participants will receiveinformation on how to use the traditional Native American teachings of the past that have had a positive effect on generations and provided a way to parent children in the kinship system. Various traditional parenting techniques will be identified, and the presenter will show how these practices might be adapted in the contemporary parent role.

Gay Munsell, M.S. (Kaw)
Program Development Specialist
National Resource Center for Youth Services
University of Oklahoma
Tulsa, Oklahoma

WORKING WITH AGGRESSIVE YOUTH

This workshop will provide session participants with intervening strategies for youth in potentially explosive situations with other youth. The presenter will focus on using individual relationships that are developed with children along with verbal and non-verbal communication skills to prevent crises from erupting into violence.

Gloria Bellymule, R.N. (Cheyenne)
AIDS Counselor
Talking Circle
Oklahoma City Indian Clinic
Oklahoma City, Oklahoma

AIDS: THE CONDITION AND ITS IMPLICATION ON MENTAL HEALTH

AIDS is a word that brings about feelings of anxiety, despair and fear of death. In today's society, the ever-increasing problem of AIDS has had an impact on the mental health of its victims. In this candid presentation of the disease and its effects, the physical and psycho-social aspects of AIDS will be discussed to give participants a clear picture of the disease as a whole.

Pamela Jumper Thurman, Ph.D. Candidate (Cherokee)
Human Services Director
Community House—Indian Health Resource Center
Tulsa, Oklahoma

HYPERACTIVE KIDS (EMOTIONAL ATTENTION DEFICIT DISORDERS)

Information on the hyperactivity in youth will be presented in this workshop. Many of these youth have been diagnosed as having learning disabilities, but actually have emotional, social and family problems stemming from the effects of alcoholism, grief and loss, family dysfunctionalism, etc. The how-tos of working with these youth and their limitations, the best way to structure, and what parents can and cannot expect of their hyperactive youth will also be included in this presentation.

Teresa LaFramboise, Ph.D. (Miami)
Assistant Professor of Counseling Psychology
Stanford University
School of Education
Stanford, California

ZUNI ADOLESCENT SUICIDE PREVENTION CURRICULUM

Developed out of a community-based initiative for suicide prevention among Zuni tribal members, this workshop will discuss the curriculum developed for high school students that was culturally adapted to Zuni life. The curriculum was designed to assist Zuni youth in not only identifying their suicidal peers, but also referring them to appropriate resources. The primary difference between this curriculum and others is that it was designed for teachers to use in their classrooms everyday. It is an ongoing activity and includes self-control techniques for classroom use.

Deborah Jones-Saumty, M.A. (Kiowa)
Evaluation Specialist
American Indian Research & Development—Center V
Norman, Oklahoma

FAMILY STRUCTURE AND FAMILY THERAPY

This presentation will target the family as an emotional unit and how it affects the behavior and development of its children. The organization of the Native American family structure is cited as being an integral part of the life of the emotionally disturbed youth. The treatment of the dysfunctional family with emotionally disturbed children also will be highlighted.

ZHA WE NI DIG (Ojibway)
Leach Lake Reservation
Leach Lake, Minnesota

A PERSON'S FOOTPRINTS ARE HIS OWN

The traditional life of the Native American is still evident in many tribal and First Nation cultures. This workshop has been designed to help one become knowledgeable and aware about Native American culture, traditional beliefs and the values of the American Indian people. This training extends beyond cognitive understanding of cultural differences to the development of a greater sensitivity for mankind through traditional teachings.

Margaret Peake Raymond, M.S.W. (Cherokee)
Executive Director
Minnesota Indian Women's Resource Center
Minneapolis, Minnesota

FAMILY REUNIFICATION: THE MINNESOTA REUNIFICATION MODEL

The presenter will provide information about the Minnesota Reunification Model, a successful urban program that emphasizes family reunification as it applies to families whose children are labeled "at risk." Focus is on keeping the family together using the family-centered approach, prevention of unnecessary placement of children into out-of-the-home environments, and reuniting children with parent(s) or extended family member(s) if separation has already occurred.

Panel Presentation
Moderator: Matthew Kauley, B.S. (Kiowa)
Executive Director
Viet Nam Era Inter-Tribal Organization Association
Oklahoma City, Oklahoma

"Encircling Our Forgotten: A Conference on Mental Health Issues for the Emotionally Disturbed North American Indian Child and Adolescent"

Sponsored by: American Indian Institute
Continuing Education and Public Service
The University of Oklahoma
Anita Chisholm, Director

The DMH Child and Adolescent Service System Program (CASSP)
Rock Richardson, Director

Oklahoma Area Indian Health Service (OAIHS)
Tom Laws, Deputy Chief, Human Services Branch

The Oklahoma State Department of Mental Health

Department of Human Services, State of Oklahoma

The American Indian Law Center Inc.
Marc Mannes, Senior Program Manager

Dates: May 31–June 1, 1989

Times: Registration from 8 to 9 a.m., Wednesday, May 31.

The conference will adjourn at 4:30 p.m. Thursday, June 1.

Location: Sheraton Century Center Hotel
One North Broadway
Oklahoma City, Oklahoma
(405) 235-2780
1-800-325-3535 (U.S. and Canada)

The American Indian Institute at the University of Oklahoma, the Child and Adolescent Service System, and the Oklahoma Area Indian Health Service are pleased to announce the Second Annual "Encircling Our Forgotten Conference, which focuses specifically on mental health problems and issues impacting North American Indian children and adolescents.

This year's conference will be at the Sheraton Century Center Hotel in downtown Oklahoma City May 31–June 1, 1989—again, directly preceding the RED EARTH '89 Native American celebration (explained elsewhere in this brochure). This conference represents a unique opportunity for Indian and non-Indian mental health practitioners and professionals, parents and other concerned individuals to join together and share their concern for the welfare of seriously emotionally disturbed Indian young people.

The problem of seriously emotionally disturbed (SED) children and adolescents has been the topic of concern at the federal, state, local and tribal levels across North America. These SED youth problems are manifested in the increase of runaway Indian youth, suicide, juvenile delinquency, and the numbers of youth that are incarcerated or institutionalized.

Much of the stress these young people are experiencing is directly related to familial disruption or dysfunctionalism. Because the family unit is such an important part of any individual's life and mental health, the theme for this year's conference is "Family Preservation." Although family preservation is not always possible in every incidence and SED children and adolescents must be removed from their families, it goes without saying that a cohesive, well-adjusted family unit can be the basis for developing mentally healthy youth.

This year's conference addresses the mental health needs of families that have SED youth within their structure through lectures; presentations; and workshops that focus on cultural identity, fetal alcohol effects, developmental disorders such as disruptive behavior disorders, oppositional/defiant disorders, and suicidal tendencies.

A model urban program that stresses family reunification will also be presented as well as an overview of other programs operating within the INTACT system. Family therapy, traditional parenting practices, and traditional beliefs and practices will be a part of the agenda. The concept of AIDS—the disease—and its effects on the mental health of Native Americans afflicted with this fatal disease will be introduced as a growing concept in mental health.

We hope you will be a part of this important gathering. Presenters will be sharing a wide range of experiences and programs that address the needs of Indian SED children and adolescents. Interaction between and among conference participants and presenters—all dedicated to developing initiatives that will encircle our forgotten—will prove a most valuable and rewarding experience for us all.

Our goal is to gain insights and information that will further assist us in our efforts to provide the best possible continuum of care through interagency networking and coordinating and providing assistance to those families that can restructure and provide homes for their youth. This includes providing the highest quality services in the least restrictive environment for our SED Indian children and adolescents. To reiterate our statements from last year, we cannot allow these young people to be forgotten. They represent our next generation of parents and community members and cannot be left to be SED adults.

PARTICIPANTS

- Indian child welfare and family services coordinators and staffs.
- Tribal and First Nations members, chairpeople and leaders.
- Mental health personnel in tribal or First Nations programs.
- Mental health personnel in federal or provincial and state governments.
- Urban Indian Health Centers across North America.
- Human services personnel from several states and the CASSP, NIMH offices.
- CASSP Technical Assistance Center staff.
- Private practicing psychologists and psychiatrists.
- Mental health personnel from private, non-profit mental health centers.
- Parents and extended family members of SED children and adolescents.
- All others who understand the need to provide the best possible services to Indian SED children and adolescents.

OUR CONFERENCE HOTEL

The conference headquarters for "Encircling Our Forgotten" is Oklahoma City's four-star hotel, the Sheraton Century Center Hotel. Located in the heart of downtown Oklahoma City at One North Broadway, the Sheraton Century has 400 deluxe rooms and "a hotel within a hotel" in the Sheraton Towers, which offer tastefully appointed guest rooms and suites, private elevators, concierge service plus many other extra amenities. Other features include a shopping mall adjacent to the lobby level, which offers specialty shops and restaurants like Greybill's, The Sunshine Express Coffee Shop, Branigans Club and fast food restaurants. The hotel is connected with several blocks of underground concourse, also lined with shopping areas and restaurants. An 18-hole miniature golf course, located adjacent to the outdoor pool area, has a snack bar and concessions.

The Sheraton Century Center Hotel is centrally located and near all major Oklahoma City attractions and points of interest. Located near the Myriad Convention Center and the Myriad Gardens, the Sheraton has more than 17,000 feet of meeting space.

A special room rate has been made available to conference participants. To qualify for the $59 single/double, $69 triple, or $79 quadruple occupancy rate, which includes a continental breakfast, please be sure to indicate that you are a participant in "Encircling Our Forgotten." Deadline for room reservations at these special rates is May 17, 1989. Reservations placed after this date will be based on availability and charged at the current rate. The toll-free reservation number for the United States and Canada is 1-800-325-3535 or you can call (405) 235-2780.

The Sheraton Century Center provides complimentary shuttle service from Will Rogers World Airport to the hotel.

- STATEMENT OF JERRY HAWLEY -
ATTACHMENT 3

8th ANNUAL NATIONAL VETERANS CONFERENCE & POW-WOW

PRICE $2.00

VIETNAM ERA VETERANS INTER-TRIBAL ASSOCIATION

PROGRAM 1989

THE FORGOTTEN WARRIOR

Theme:

NATIVE AMERICAN VETERANS;
HAVE WE BEEN FORGOTTEN?

Our Warmest
Vietnam Era Veterans
Inter-Tribal Association

WELCOMES

Nam Brothers
Nam Sisters
WW 1Veterans
WW 2 Veterans
Korea Veterans
Gold Star Mothers
War Mothers
Spouses
Families
Friends
and
Relatives

Theme:
NATIVE AMERICAN VETERANS; HAVE WE BEEN FORGOTTEN?

PROGRAM

THURSDAY, JUNE 8, 1989

10:00 a.m. - 9:00 p.m.	Registration/Information Opens (Potawatomi Tribal Grounds)

VEVITA NATIONAL
BOARD OF DIRECTORS MEETING
2:00 p.m. to 5:00 p.m.
(Potawatomi Tribal Grounds)

AGENDA

Call meeting to order	Jerry Haney, National Commander
Reading of Minutes	Tom Amiotte, National Board of Directors
Financial Report	Frank Alexander, Southern Plains Regional Treasurer
Adjourn	
10:00 p.m.	Sweat Lodge (men & Ladies sweat available) (Potawatomi Tribal Grounds)
Men Sweat conducted by	Mr. Webster Bear Bow Shawnee, Oklahoma
Women Sweat conducted by	Anielia Bear Bow Shawnee, Oklahoma

8th ANNUAL NATIONAL VETERANS CONFERENCE & POW-WOW

FRIDAY, JUNE 9, 1989

Morning Sunrise	Flag Raising (Potawatomi Tribal Grounds) Mvskoko Nation Color Guard
8:OO a.m.	Registration/Information (Potawatomi Tribal Grounds)
10:00 a.m.	Department of Veterans Affairs Concurrent with Breakfast Service Representives on Site (Potawatomi Tribal Grounds) Tom Hinkle John Cloud Jerry Riley Margaret Riley

VEVITA Conference/ NVVC leadership Breakfast buffet
8:00 a.m. till 12:00 noon
(Holiday Holidome Banquet Room)
Agenda

8:30 a.m	Color Guard Mvskoko Nation Color Guard
Welcome	Jerry Haney, National Commander Shawnee, Oklahoma
	Pierre Tarson, Mayor City of Shawnee
	Mike Sovick, President Vietnam Veterans of America (VVA) Oklahoma State Council
	Clyde Stone, Vice-President Vietnam Veterans of America (VVA) Oklahoma State Council
Opening Remarks	Matthew W. Kauley, Executive Director VEVITA Oklahoma City, Oklahoma
	Tony Diamond, Executive Director & Editor in chief Veterans Outlook Brotherhood Rally of All Veterans Organization (BRAVO), California

J. Thomas Burch, Jr. Chairman
National Vietnam Veterans Coalition
(NVVC), Washingto, D.C.

10:00 a.m.
Keynote Address

"Overview of the Veterans Administration Policies and Services for the Native American Veteran"
Andrew Montano, Director
Veterans Administration Medical
Center, Albuquerque, New Mexico

11:00 a.m.

"Homeless Veterans"
Jerome E. Smith, Commander
American Ethnic Veterans of
Vietnam Inc., Indianapolis, Indiana

11:45 a.m.

"Veterans Dialog"
questions, answers, &
Announcements

12:00 Noon

Breaks for Lunch
Return to Potawatomi Tribal
Grounds for Afternoon session

Recreational Activities Start
Concurrent with Conference

1:00 p.m.

Golf Scramble
Potawatomi Tribal Grounds
FIRELAKE GOLF COURSE
OKC Indian Golf Club
Old Business

Conference Afternoon Sessions Begins
Long Room
Potawatomi Tribal Grounds
Concurrent with Golf Scramble
Agenda

1:00 p.m. - 1:50 p.m.

"POST TRAMATIC STRESS DISORDER (PTSD) AND THE TRADITIONA HEALER"
Veteran Administration
Indian Working Group:
Harold Barse, Chairman
Sydney Flame
Tom Rascon III
Glen Eagle

2:00 p.m. - 2:50 p.m.	**"VETERAN ADMINISTRATION HOME LOAN PROGRAM ON TRUST AND RESTRICTED LANDS"** David Shaw, Assistant Director Veterans Upward Bound Program VEVITA Member Humboldt State University Arcata, CA
3:00 p.m. - 3:50 p.m.	**"NATURAL RESOURCES"** Co-Presentation by: Lou Ross, National Board of Directors National Vietnam Veterans Coalition (NVVC) Salt Lake City, Utah Catherine Vandermoer, PhD. Wind River Enviromental Quality Commission Ft. Washkie, WY
4:00 p.m.	Family Rap Session Jerry Riley Margaret Riley
5:00 p.m.	Dinner

8TH ANNUAL NATIONAL VEVITA POW-WOW
5:00 p.m. till Midnight
POW-WOW GROUNDS
Schedule of Events

Head Staff

Head Stright Dancer	Andrew Grey
Head Traditional Dancer	Eddie Two Clouds
Head Fancy Dancer	George Alexander
Head Lady Dancer	Juanita Learned
Head Gourd Dancer	Lawrence Murray
Head Gourd Dance Singer	Ernest Toppah
Head War Dance Singers	Redland
Masters of Ceremony	Marvin Alexander Chris White
Co-Host Gourd Clan's	New Nation Inter-Tribal Pow Wow Club Carnegie Tia-Piah Society
Arena Directors	Gary Gover Amos Patty Walter Lamey
Flags	Beau Knight, Saturday Kenneth Harjo, Sunday

5:00 p.m. - 8:00 P.M.	**Gourd Dance Give Aways and Specials Permitted Co-Host Gourd Clan: New Nation Inter-Tribal Pow Wow Club**
8:00 p.m.	**21 Gun Salute (Combined Color Guard)**
	Grand Entry Give Aways and Specials Permitted Color Guard Mvskoko Nation Color Guard
	Introduction of VEVITA Current Reigning Princess Ms. Ora Dubray, Sioux, Rapid City, SD
	Introduction of VEVITA Chapter
	Sponsored Princesses for New National Ms. VEVITA contest
	Special Recognition for VEVITA Honoree Matthew Reed,(Kickapoo/Sac &Fox)
	Special POW/MIA Ceremony
10:00 p.m.	Sweat Lodge (men & Ladies sweat available) (Potawatomi Tribal Grounds)concurrent with Pow-Wow
Men Sweat conducted by	Mr. Webster Bear Bow Shawnee, Oklahoma
Women Sweat conducted by	Anielia Bear Bow Shawnee, Oklahoma
	Retreat
SATURDAY, JUNE 10, 1989	
Morning Sunrise	Flag Raising (Potawatomi Tribal Grounds) Oklahoma Inter-Tribal Color Guard
8:OO a.m.	Registration/Information (Potawatomi Tribal Grounds)

8th ANNUAL NATIONAL VETERANS CONFERENCE & POW-WOW

8:30 a.m.- 8:45 a.m.	Opening Remarks Kelly Haney, Oklahoma St. Senate (Potawatomi Tribal Grounds) Rocky Barrett, Chairman Potawatomi Tribe
8:45 a.m.- 9:45 a.m.	POW/MIA Issues & Visit National Encampment Pat Robertson, President Christian Broadcast Network Virginia Beach, VA
10:00 a.m.	Department of Veterans Affairs Service Represemtives on Site (Potawatomi Tribal Grounds) Tom Hinkle John Cloud Jerry Riley Margaret Riley ARCHERY COMPETITION Marvin Alexander,Director
11:00 a.m.- 1:00 p.m.	PARADE VEVITA & Santa Fe Days Parade, City of Shawnee (Downtown) Frank Alexander, VEVITA Parade Director Pat Robertson, GRAND MARSHALL
1:00 P.M.	RIFLE COMPETITION Potawatomi Tribal Grounds Frank Alexander, Range Master HORSESHOE COMPETITION Potawatomi Tribal Grounds Mike Toahty, Horseshoe Director GOLF TOURNAMENT(qualify round) FIRELAKE GOLF COURSE OKC Indian Golf Club PARACHUTE DROP Potawatomi Tribal Grounds SPECIAL BINGO PROGRAM POTAWATOMI TRIBAL BINGO HALL

2:00 p.m.	**Gourd Dance Give Aways and Specials Permitted Co-Host Gourd Clan: Carnegie Tia-Piah Society**
5:00 p.m.	Supper
6:30	Gourd Dance continues
7:30 p.m.	**Grand Entry Give Aways and Specials Permitted POTAWATOMI TRIBAL POW-WOW GROUNDS** Color Guard Oklahoma Inter-Tribal Color Guard Princess Coronation & Special
10:00 p.m.	Sweat Lodge (men & Ladies sweat available) (Potawatomi Tribal Grounds) concurrent with Pow-wow
Men Sweat conducted by	Mr. Webster Bear Bow Shawnee, Oklahoma
Women Sweat conducted by	Anielia Bear Bow Shawnee, Oklahoma
	Retreat
SUNDAY, JUNE 11, 1989	
	Flag Raising (Potawatomi Tribal Grounds) Morning Star Color Guard
7:30 a.m.	Golf Tournament Tee Off
8:OO a.m.	Registration/Information (Potawatomi Tribal Grounds)
9:00 a.m. - Noon	Sunday Morning Church Service (Potawatomi Tribal Grounds) Harold Barse, Coordinator Indian Gospel Music Program Vietnam Veterans Testimonies
1:00 p.m.	Department of Veterans Affairs Service Representives on Site

8th ANNUAL NATIONAL VETERANS CONFERENCE & POW-WOW

	(Potawatomi Tribal Grounds) Tom Hinkle John Cloud Jerry Riley Margaret Riley
2:00 p.m.	Grand Entry, no specials SEMINOLE NATION COLOR GUARD
	Preliminary Dance Competition Womens Fancy Shawl Womens Jingle Womens Cloth Womens Buckskin Mens Stright Men Traditional Men Fancy
7:00 p.m.	Grand Entry Seminole Nation Color Guard
7:30 P.M.	Finals Dance Competition Womens Fancy Shawl Womens Jingle Womens Cloth Womens Buckskin Mens Stright Men Traditional Men Fancy
	Retreat

1990 9th Annual VEVITA National Conference & Pow-Wow is Scheduled to be in Montana. The Agenda is currently being planned, should you have a desire to assist or be a presenter inform Matthew Kauley, Ex. Director

NATIVE AMERICANS KIA/MIA VIETNAM 1957- '84

Our Gallant Warriors

ALASKA

AK Barr	Edward	Nasuesak	Brevig Mission	Navy	SN	5/3/69	RVN	Non-Hostile
AK Barr	Thomas	M	Anchorage	Army	SP5	5/12/69	RVN	Hostile, Killed
AK Elsovsky	David	Henry	Cordova	Army	SGT	12/23/66	RVN	Hostile, Killed
AK Gamble, Jr	Charles	F	Juneau	Army	SP4	10/28/69	RVN	Non-Hostile
AK Ivey	Sam		McGrath	Army	PFC	9/16/65	RVN	Non-Hostile
AK Kilbuck	George	Gregory	Bethal	Army	PFC	8/27/65	RVN	Hostile
AK Paulsen	Warren		Valdes	Navy	BM3	6/23/69	RVN	Hostile, Killed

ARKANSAS

AR Rainwater	Jewel	Lee	Van Buren	Army	PFC	3/2/68	RVN	Hostile, Killed

ARIZONA

AZ Addkai, Jr	Alvin		Window Rock	Army	PFC	5/14/71	RVN	Hostile, Killed
AZ Arkue	Vallance	Galen	Parker	Marines	CPL	9/3/67	RVN	Hostile, Killed
AZ Arientino	Dudney	Nelson	Coolidge	Army	SP4	12/7/67	RVN	Hostile, Killed
AZ Begody	Harold	L	Tuba City	Army	SP4	2/14/68	RVN	Hostile, Killed
AZ Billie	Larry	Rogers	Chinle	Marines	PFC	10/11/66	RVN	Hostile, Killed
AZ Blackwater	Dwight	Thomas	Phoenix	Army	1LT	6/19/71	RVN	Non-Hostile
AZ Chester	Alvin		Window Rock	Marines	LCPL	7/5/65	RVN	Non-Hostile
AZ Claw	Peter	Yazzie	Kayenta	Army	PFC	4/5/68	RVN	Hostile, Killed
AZ Crook	Elliott		Phoenix	Army	SP5	5/17/72	RVN	Hostile
AZ Dale	Bennie		Wide Ruins	Army	SP4	5/12/68	RVN	Hostile, Killed
AZ Daw	Jerry	Lorenzo	Tonalea	Army	CPL	6/8/67	RVN	Hostile, Killed
AZ Denipah	Daniel	Dee	Tuba City	Marines	LCPL	12/28/67	RVN	Hostile, Killed
AZ Francisco	Patrick	Phillip	Stanfield	Marines	LCPL	4/26/67	RVN	Hostile, Killed
AZ Hawthorne	Gene		Lupton	Army	SSGT	5/4/66	RVN	Non-Hostile
AZ Hicks	Donald		Tonalea	Army	SP4	6/30/68	RVN	Hostile, Killed
AZ Hickson	Leonard	Martin	Ft. Defiance	Army	SGT	5/18/69	RVN	Hostile, Killed
AZ Huskon	Benny	Leo	Leupp	Army	SP4	6/7/68	RVN	Non-Hostile
AZ Jackson	Ralford	John	Tuba City	Marines	PFC	5/22/69	RVN	Hostile, Killed
AZ Jones	Michael	Bruce	Mohave	Army	PFC	5/12/68	RVN	Hostile, Killed
AZ Kee	Wilson	Begay	Chinle	Army	SP4	6/17/70	RVN	Hostile, Killed
AZ Maloney	Oscar		Tuba City	Army	SP5	11/2/70	RVN	Non-Hostile
AZ Marietta	Harold	Joseph	Sacaton	Army	SGT	2/7/66	RVN	Hostile, Killed
AZ Pashano	Jack	Poola	Polacca	Army	SP4	8/19/68	RVN	Hostile, Killed
AZ Patten	Jimmie		San Carlos	Army	SGT	1/31/68	RVN	Hostile, Killed
AZ Perkins	David	Drake	Coolidge	Army	PFC	10/11/66	RVN	Hostile, Killed
AZ Pete, Jr.	Franklin	Danny	Sacaton	Army	SP4	5/27/68	RVN	Hostile, Killed
AZ Romero	Michael	Andrew	Sells	Marines	LCPL	3/15/70	RVN	Hostile, Killed
AZ Ruiz	Peter	George	Ajo	Marines	PFC	5/29/68	RVN	Hostile

VIETNAM ERA VETERANS INTER-TRIBAL MEMORIAL

ARIZONA

AZ Slim	Jimmie	Farrell	Cow Springs	Marines	PVT	6/4/70	RVN	Non-Hostile
AZ Sota	Bravie		Somerton	Army	SGT	9/5/67	RVN	Hostile, Killed
AZ Stands, Jr.	Daniel	Gilbert	Phoenix	Army	PFC	3/18/66	RVN	Hostile, Killed
AZ Tsosie	Albert		Chinle	Marines	LCPL	7/10/70	RVN	Hostile, Killed
AZ Tsosie	Lee	Dino	Cross Canyon	Army	CPL	7/25/68	RVN	Non-Hostile
AZ Yazzie	Leonard	Lee	Pinon	Marines	PFC	5/28/68	RVN	Hostile, Killed

CALIFORNIA

CA Acosta	John	Michael	Sacramento	Army	PFC	1/21/68	RVN	Hostile
CA Barnos	James	Patrick	Lemoore	Army	SP4	12/12/69	RVN	Hostile, Killed
CA Battiest	Andrew		Calipatria	Army	CPL	6/25/68	RVN	Hostile, Killed
CA Brown, Jr.	Randolph		North Highlands	Marines	LCPL	2/12/69	RVN	Hostile, Killed
CA Campbell	Eugene	Charles	Redwood Valley	Marines	LCPL	8/27/67	RVN	Non-Hostile
CA Dewey	Eric	Melvin	Bishop	Marines	PFC	7/29/67	RVN	Hostile, Killed
CA Dunsing	Dennis	Paul	Ukiah	Army	PFC	5/6/68	RVN	Hostile, Killed
CA Henry	Robert	Gregory	San Diego	Army	PVT	6/25/68	RVN	Hostile, Killed
CA Hummingbird	Ferrell		Oakland	Marines	LCPL	1/14/67	RVN	Hostile, Killed
CA Pinole	Babe		Santa Rosa	Marines	LCPL	12/7/68	RVN	Hostile, Killed
CA Rader	Gary	Philip	Sacramento	Army	SP4	5/7/70	RVN	Non-Hostile
CA Ray	Darwin	Esker	East Highlands	Army	CPL	1/3/68	RVN	Hostile
CA Roberson	Arthur	Paul	Banning	Army	SP4	6/19/71	RVN	Hostile, Killed
CA Rose	Leonard	Dale	Herlong	Marines	PFC	1/23/69	RVN	Hostile, Killed
CA Rowe	William	Edwin	Costa Mesa	Army	SSGT	3/21/69	RVN	Hostile, Killed
CA Siow	Gale	Robert	Huntington Park	Navy	ATN	31/11/68	Laos	Hostile
CA Starkey	Henry	Morgan	Auburn	Army	PFC	2/14/66	RVN	Hostile, Killed
CA Sterling	John	Charles	Concord	Army	CPL	9/5/69	RVN	Hostile
CA Williams	James	Alec	Bishop	Marines	LCPL	7/1/68	RVN	Hostile, Killed
CA Willis	Harold	Eugene	Bishop	Army	PFC	1/25/66	RVN	Non-Hostile
CA Wilson	Adam		San Diego	Army	WO	11/15/69	RVN	Hostile, Killed
CA Winkempleck	George	Harold	Porterville	Army	PFC	10/10/67	RVN	Hostile
CA Nadal	Baldomero	Arturo	Delano	Army	CPL	4/15/67	RVN	Hostile, Killed

CONNECTICUT

CT Manselle, III	Eugene	L	Hartford	Army	PVT	6/19/68	RVN	Hostile, Killed

COLORADO

CO Ortiz	Randall	Issac-Jed	Denver	Marines	LCPL	8/20/69	RVN	Hostile,Killed

IOWA

IA Roberts	Terry		Ottumwa	Marines	PFC	12/20/67	RVN	Hostile
IA Youngbear	Richard	Clive	Tama	Army	SGT	2/3/66	RVN	Hostile, Killed

NATIVE AMERICANS
KIA/MIA VIETNAM 1957- '84

ILLINOIS

IL Parkhurst	Vincent	Bertram	Chicago	Army	SFC	2/20/68	RVN	Hostile, Killed

KANSAS

KS Hale	Victor		Topeka	Marines	LCPL	12/8/68	RVN	Hostile, Killed
KS Malone	Robert	Gary	Wichita	Marines	CPL	7/28/66	RVN	Hostile, Killed

MASSACHUSETTS

MABernard	Vincent		Dorchester	Marines	LCPL	9/21/68	RVN	Hostile, Killed

MAINE

ME Shay, Jr.	Lawrence	William	Portland	Marines	LCPL	6/15/66	RVN	Hostile, Killed

MICHIGAN

MI Cruz	Frank	Bryan	Detroit	Army	PFC	7/27/67	RVN	Hostile, Killed
MI Fraser	Thomas	Edwin	Detroit	Marines	PVT	3/4/70	RVN	Non-Hostile
MI Howard	Charles	Vincent	Brimley	Army	SGT	7/2/66	RVN	Hostile, Killed
MI Smith	Preston	Lee	Essexville	Army	1LT	9/5/70	RVN	Non-Hostile

MINNESOTA

MN Beaulieu	Leo	Vernon	Lengby	Marines	PFC	5/16/66	RVN	Hostile, Killed
MN Bellanger	John	George	Minneapolis	Marines	LCPL	2/14/68	RVN	Hostile, Killed
MN Cloud	Ronald	Myron	Poremah	Army	SGT	7/4/68	RVN	Hostile, Killed

MISSOURI

MO Schmidt	Frederick	Charles	Parkville	Army	PFC	4/23/67	RVN	Non-Hostile

MONTANA

MT Chopper	Franklin	Delano	Brockton	Army	PFC	6/13/67	RVN	Hostile, Killed
MT Fisher	William	John	Arlee	Marines	LCPL	9/22/66	RVN	Non-Hostile
MT Healy	Louis	Glenn	Dodson	Marines	PVT	7/5/68	RVN	Hostile, Killed
MT Incashola	Jean	Baptiste	St. Ignatius	Army	PFC	11/23/66	RVN	Non-Hostile
MT Pokerjm	Joseph	Louis	St. Ignatius	Army	PVT	10/12/67	RVN	Hostile, Killed
MT Teeth	Austin		Lame Deer	Marines	PFC	4/28/69	RVN	Non-Hostile
MT Walsh	Truman	J	Dodson	Army	SP4	2/25/69	RVN	Hostile, Killed

NORTH CAROLINA

NC Austin	William	Eugene	Lenoir	Army	SGT	7/31/70	RVN	Hostile, Killed
NC De Vaney	James	Price	Goldsboro	Army	CPL	2/28/70	RVN	Hostile, Killed
NC Locklear	Jimmy		Maxton	Army	SP4	9/4/68	RVN	Hostile

NORTH DAKOTA

ND Alberts	Roger	Duane	Ft. Totten	Army	PFC	2/5/68	RVN	Hostile, Killed
ND Davis	Christopher	Wilmer	Belcourt	Army	SP4	3/18/67	RVN	Non-Hostile
ND Goodiron	Ronald	Christy	Shields	Marines	PFC	2/28/68	RVN	Hostile, Killed
ND Levings	James	M	New Town	Army	SGT	5/23/68	RVN	Non-Hostile

NEBRASKA

NE Anderson	Dennis	Williams	Norfolk	Army	SSGT	12/11/66	RVN	Non-Hostile
NE Wolfe	Matthew		Macy	Army	PFC	2/1/68	RVN	Hostile, Killed

NEW MEXICO

NM	Antonio, Jr	Johnnie		Crown Point	Marines	LCPL	12/27/67	RVN	Hostile, Killed
NM	Arthur	Johnny		Fruitland	Army	SP5	6/10/71	RVN	Hostile, Killed
NM	Arviso	Herbert		Farmington	Army	SGT	10/26/69	RVN	Hostile, Killed
NM	Atole	Floyd	Samuel	Dulce	Army	SGT	2/21/69	RVN	Hostile, Killed
NM	Barney	Luther		Mexican Springs	Army	SP5	12/21/71	RVN	Non-Hostile
NM	Begaye	Eddie	Charles	Ramah	Marines	CPL	5/25/67	RVN	Hostile, Killed
NM	Begaye	Felix	Dohaltahe	Little Water	Marines	PFC	12/10/67	RVN	Non-Hostile
NM	Charlie	Peter		Farmington	Marines	LCPL	8/8/70	RVN	Hostile, Killed
NM	Chino	Gerald	Gregory	Cubero	Army	SP4	3/24/68	RVN	Hostile, Killed
NM	Cutley	Albert	Allan	Cubero	Marines	PFC	3/30/67	RVN	Hostile, Killed
NM	Dempsey	Warren	Leigh	Church Rock	Marines	CPL	12/3/65	RVN	Hostile, Killed
NM	Etsitty	Val		Gallup	Army	CPL	6/1/68	RVN	Hostile, Killed
NM	Fragua	George	Leonard	Jemez Pueblo	Army	PFC	12/25/66	RVN	Non-Hostile
NM	Ghahate	Luther	Anderson	Zuni	Army	SP4	10/21/68	RVN	Hostile, Killed
NM	Hayes	Thomas		Shiprock	Army	SGT	12/27/68	RVN	Hostile, Killed
NM	James	Billie		Farmington	Army	SP4	4/15/68	RVN	Hostile, Killed
NM	Johnson	Zane	Everett	Fruitland	Marines	LCPL	3/27/69	RVN	Non-Hostile
NM	Largo	Calvin	David	Shiprock	Army	SP4	9/19/68	RVN	Hostile, Killed
NM	Martin	Emerson		Churchrock	Marines	PFC	5/29/69	RVN	Hostile Killed
NM	Martinez	Bobby	Joe	Ft Wingate	Army	SGT	5/11/68	RVN	Hostile, Killed
NM	Martinez	Manuel		Taos Pueblo	Navy	BM1	2/27/69	RVN	Hostile, Killed
NM	Mike	Steven		Gallup	Army	PFC	1/6/71	RVN	Non-Hostile
NM	Montoya	Joe	Ned	San Juan Pueblo	Army	CPL	8/1/67	RVN	Non-Hostile
NM	Muniz	Daniel	Harold	Dulce	Army	PVT	5/17/70	RVN	Non-Hostile
NM	Muskett	Wayne		Shiprock	Marines	LCPL	8/26/69	RVN	Hostile
NM	Pena	Ernest	Delbert	Zuni	Army	SP4	9/13/68	RVN	Hostile, Killed
NM	Patero	Raymond		Canoncito	Army	PFC	1/26/70	RVN	Hostile, Killed
NM	Sombrero	Jose	Scotty	Penasco	Army	PVT	6/17/66	RVN	Hostile, Killed
NM	Toya	Frank		Jemez Pueblo	Army	PFC	5/15/67	RVN	Hostile
NM	Toledo	Thomas	Ambrose	Jemez Pueblo	Army	SP4	3/6/71	RVN	Hostile, Killed
NM	Tosa	Antonio	Tony	Jemez Pueblo	Army	PVT	7/17/71	RVN	Non-Hostile
NM	Wilson	Juan	Jay	Thoreau	Marines	LCPL	2/14/69	RVN	Hostile, Killed
NM	Yazzie	Dan		Continental Divide	Army	SP4	5/15/69	RVN	Non-Hostile
NM	Yazzie	Jones	Lee	Tohatchi	Marines	LCPL	8/4/68	RVN	Hostile, Killed
NM	Yazzie	Raymond		Church Rock	Marines	CPL	2/26/69	RVN	Hostile, Killed

NEVADA

NV	Allen	John	Ike	Reno	Marines	PFC	3/7/69	RVN	Hostile, Killed
NV	Jackson	Lloyd	Wilmer	Austin	Army	SGT	5/7/70	RVN	Hostile, Killed
NV	LeBeau, Jr	Andrew	Ernest	Sparks	Air Force	SSGT	2/11/68	RVN	Hostile, Killed
NV	Molino, Jr	Eddie		Fallon	Army	CAPT	5/10/70	Cambodia	Non-Hostile
NV	Muncey	Jay	Allan	Battle Mountain	Army	SP4	8/28/70	RVN	Hostile, Killed
NV	Parker	Larry		Winnemucca	Army	SSGT	3/21/70	RVN	Hostile, Killed
NV	Sam	Wilfred	Gerald	Elko	Marines	PFC	4/7/69	RVN	Hostile, Killed

NEW YORK

NY	Bigtree	James	Victor	Syracuse	Marines	CPL	12/11/66	RVN	Hostile
NY	Boswell	David	Henry	Buffalo	Navy	HN	3/6/68	RVN	Hostile, Killed
NY	Doctor	Gary	Dean	Basom	Marines	LCPL	10/7/66	RVN	Hostile, Killed
NY	General	Leslie	Neil	Niagara Falls	Mariens	CPL	5/1/68	RVN	Hostile, Killed
NY	Green	Larry		Niagra Falls	Marines	PFC	1/9/69	RVN	Hostile, Killed
NY	Snow, Jr	Milton		East Aurora	Army	PFC	10/11/67	RVN	Hostile, Killed
NY	Tarbell	Clifford	Lawrence	Bombay	Army	SP4	4/11/70	RVN	Hostile, Killed
NY	Tarbell	William	M	Syracuse	Army	PVT	2/26/66	RVN	Hostile, Killed

NATIVE AMERICANS
KIA/MIA VIETNAM 1957- '84

OKLAHOMA

OK Armstrong	Dean	Edward	Atoka	Marines	GSGT	5/13/67	RVN	Hostile, Killed
OK Baker	Elwood		Battiest	Marines	LCPL	6/24/67	RVN	Non-Hostile
OK Barnett	Paul	Wayne	Dustin	Army	SP4	1/3/69	RVN	Hostile, Killed
OK Bear	Donald	Earl	Mountain View	Army	SFC	7/8/68	RVN	Hostile, Killed
OK Blacklox	Robert	Lee	Tahlequah	Marines	PFC	2/17/70	RVN	Hostile, Killed
OK Briseno	Johnny	Charles	Waynoka	Marines	PFC	6/18/70	RVN	Hostile
OK Bruner	David		Sapulpa	Army	SP4	5/14/69	RVN	Hostile, Killed
OK Carney	Joshua	Eli	McAlester	Army	SSGT	2/12/71	RVN	Hostile, Killed
OK Christy	Gilmore	Wilson	Tulsa	Army	SP4	2/6/67	RVN	Hostile, Killed
OK Deer	Terry	Louis	Wewoka	Army	PFC	10/5/70	RVN	Non-Hostile
OK Deere	Charles	Kenneth	Okemah	Army	PFC	5/5/68	RVN	Hostile, Killed
OK Deerinwater	Bruce	Edward	McAlester	Army	SSGT	1/25/69	RVN	Hostile, Killed
OK Durant, Jr.	Forbis	Pipkin	Atoka	Marines	LCPL	3/10/68	RVN	Hostile
OK Eisenberger	George	Joe BU	Pawukuska	Army	SGT	12/5/65	RVN	Hostile
OK Going	Wallace		Watson	Navy	BM2	12/23/68	RVN	Hostile, Killed
OK Gritts	William	Archie	Hulbert	Army	CPL	6/13/68	RVN	Hostile, Killed
OK Harjo	Kenneth	DeWayne	Seminole	Army	SP4	11/8/69	RVN	Hostile, Killed
OK Henshaw	Larry	Roy	Sapulpa	Army	SGT	5/1/70	RVN	Hostile, Killed
OK Ingram	John	Lee	Weleetka	Marines	PFC	4/7/68	RVN	Hostile, Killed
OK Johnson	Clifford	Curtis	Fairfax	Army	CWO	1/29/66	RVN	Hostile, Killed
OK Kipp	Raymond	Sidney	Oklahoma City	Army	SP4	3/17/70	RVN	Hostile, Killed
OK LeClair	Prentice	Dale	Tulsa	Army	SP4	8/9/67	RVN	Hostile, Killed
OK Little Sun	Thomas	Lee	Pawnee	Marines	PFC	2/16/68	RVN	Hostile, Killed
OK Mackey	Talton	Lee	Red Oak	Army	SGT	12/9/68	RVN	Hostile, Killed
OK Miller	Charles	Daniel	Wewoka	Marines	LCPL	3/31/68	RVN	Hostile, Killed
OK Noah	Josh	Cain	Hugo	Army	SGT	11/20/67	RVN	Hostile
OK Noah	Marvin	Tidwell	Broken Bow	Marines	LCPL	3/24/67	RVN	Hostile, Killed
OK Okemah	John		Harrah	Army	SFC	3/13/68	RVN	Hostile
OK Pahcheka	Robert	Carlos	Indianhoma	Marines	PFC	10/22/68	RVN	Hostile, Killed
OK Pappin	John	Patrick	Pawhuska	Navy	CR	3/12/70	RVN	Non-Hostile
OK Pesewonit	Russel	Eugene	Lawton	Marines	PFC	7/22/66	RVN	Hostile, Killed
OK Poolaw, Sr.	Pascal	Cleatus	Apache	Army	FSGT	11/7/67	RVN	Hostile, Killed
OK Ridge	Jesse	Lee	Park Hill	Army	PFC	6/9/69	RVN	Non-Hostile
OK Sawney	Jackie	Lee	Tulsa	Army	SP4	1/10/71	RVN	Hostile, Killed
OK Thompson, Jr.	Turner	L	Talihina	Army	CPL	7/19/66	RVN	Hostile
OK Tyler	Edward		Oklahoma City	Army	PFC	5/9/68	RVN	Hostile, Killed
OK Vetter, Jr.	Ernest		Oklahoma City	Army	PFC	4/18/68	RVN	Hostile, Killed

PENNSYLVANIA

PA Sampson	Gerald	Hilbert	Williamsport	Marines	CAPT	8/28/69	RVN	Hostile, Killed

SOUTH CAROLINA

SC Harris	Carl	E	Rock Hill	Army	SGT	11/5/65	RVN	Hostile, Killed
SC Simmers	Garold	Ray	Rock Hill	Marines	PFC	2/24/69	RVN	Hostile, Killed

SOUTH DAKOTA

SD Baltezar	Theodore		Gregory	Army	SP4	6/20/70	RVN	Hostile, Killed
SD Bettleyoun	Percy		Rapid City	Marines	CPL	5/28/68	RVN	Hostile, Killed
SD Flying Horse	Conrad	Lee	McIntosh	Marines	LCPL	8/31/70	RVN	Hostile

SOUTH DAKOTA

SD Frenier	Irving	F	Sisseton	Army			RVN	Hostile, Killed
SD Hatle	Theodore		Sisseton	Army			RVN	Hostile, Killed
SD Jackson	Michael	Meredith	Waubay	Army	PFC	3/24/66	RVN	Hostile
SD Jamerson	Kenneth	Robert	Little Eagle	Marines	LCPL	4/5/67	RVN	Hostile
SD Jealous-of-Him	FrankW		Wounded Knee	Army	SP4	6/9/69	RVN	Hostile, Killed
SD LeBeaux	Loren		Wakpala	Army	SP4		RVN	Hostile, Killed
SD PaPointe	Larry		Rosebud				RVN	Hostile, Killed
SD Matthews, Jr	Gilbert	Lewis	Pine Ridge	Army	CAPT	6/24/71	RVN	Non-Hostile
SD McDowell	John	Clark	Corsica	Army	CPL	1/9/68	RVN	Hostile
SD McPherson	Dennis		Gregory	Army	PFC	11/11/67	RVN	Hostile, Killed
SD Mills	Arthur	Lee	Rapid City	Marines	LCPL	4/12/68	RVN	Hostile, Killed
SD Red Hawk	Jesse	Milton	Pine Ridge	Army	PVT	11/10/68	RVN	Non-Hostile
SD Renville	Arden	Keith	Sisseton	Army	SP4	4/24/68	RVN	Hostile, Killed
SD Roach	Orlando	Silas	Eagle Butte	Army	SP4	12/27/66	RVN	Non-Hostile
SD Roy	Russell		Mission	Marines	LCPL	7/13/71	RVN	Hostile, Killed
SD Spider	Alvin	Richard	Fort Thompson	Army	PFC	5/18/67	RVN	Hostile, Killed
SD Two CrowBlair		William	Kyle	Army	PFC	12/4/68	RVN	Hostile
SD Twoeagle	Gabriel	Lawrence	Parmelee	Army	PVT	4/18/71	RVN	Non-Hostile
SD White MauseJoseph		Lewis	Ft. Thompson	Army	PFC	4/8/71	RVN	Non-Hostile
SD Yellow Elk	Carlos	Nichola	Milesville	Army	PFC	8/29/68	RVN	Hostile, Killed
SD Zegler	Thomas		Ft. Thompson	Army	SP4	4/8/71	RVN	Hostile, Killed

TEXAS

TX Cano	Jose	Ramon	Austin	Army	SP4	1/15/69	RVN	Hostile, Killed
TX Meshigaud	Andrew	Harry	Dallas	Army	SSGT	12/17/71	RVN	Hostile, Killed
TX Robinson	Marvin	Ray	Livingston	Army	SP5	9/11/69	RVN	Non-Hostile
TX Taylor	Ernest	Vernon	Dallas	Marines	PFC	2/5/68	RVN	Hostile, Killed
TX Thompson	Ortha	Theander	Fort Worth	Marines	CPL	8/24/65	RVN	Non-Hostile

UTAH

UT Cuch	Wilbert	Wayne	Springville	Marines	LCPL	5/26/68	RVN	Hostile, Killed
UT Kanosh	Wilbert	Dwayne	Vernal	Marines	CPL	1/30/69	RVN	Non-Hostile
UT Mermejo	Joseph	Michael	Stockton	Marines	PFC	3/29/69	RVN	Hostile, Killed

WASHINGTON

WASmith, Jr.	Gus		Oso	Army	SP4	4/25/70	RVN	Hostile

WISCONSIN

WI Butler	Lawrence	Joseph	Hayward	Army	SP4	4/4/69	RVN	Hostile
WI Christjohn	Paul	Emerson	Oneida	Army	PFC	9/9/68	RVN	Non-Hostile
WI Fredenberg	Ralph		Shawano	Army	SP4	4/24/68	RVN	Hostile
WI Pamonicutt	Martin	James	Neopit	Marines	PFC	6/23/69	RVN	Hostile, Killed
WI Sutton	Larry	Ivan	Danbury	Army	SP4	7/23/67	RVN	Hostile, Killed
WI Tousey	Gearwin	Philip	Green Bay	Army	PFC	2/25/68	RVN	Hostile, Killed

WYOMING

WY Moss	Weldon	Dale	Ethete	Marines	PFC	4/2/68	RVN	Hostile, Killed
WY Snyder	Roy	Jasper	Ft. Washakie	Army	CPL	5/25/70	Cambodia	Hostile, Killed

CANADA

Corbiere	Austin	Morris	Canada	Marines	LCPL	5/9/68	RVN	Non-Hostile

WE HONOR AND SUPPORT
OUR VIETNAM ERA
VETERANS

OUR FUTURE DEPENDS ON
YOU
YOU HONOR US

POTLATCH NETWORK
LEE ALLEN, FOUNDER

Bravo VEVITA

BRAVO *Salutes the* **Vietnam-Era Inter Tribal Association,** *its members and supporters on this the* **8th Annual VEVITA Pow Wow** *in Shawnee, Oklahoma.*

Please fill out the **Buddy Search** form below and you will receive a FREE suscription to **The Veterans Outlook,** as a token of our appreciation for your participation and support of this great association.

BRAVO Buddy Search/Unit Registration

To better serve the veteran community BRAVO is expanding on its BUDDY SEARCH to include all veterans of all wars and peace. This purpose is in keeping with our objectives of being the primary communications forum for all veterans. If you should see a *BUDDY* - someone you have been searching for, write to them in care of *BUDDY/BUDDY SEARCH.* We appreciate your assistance in this endeavor by copying this form and passing it on. Fill out one yourself and return it to us. **"Getting it together - together."**
Thank you and keep the spirit, brother grunt.

NAME: _____ DATE: _____

VETERAN OF: VIETNAM ☐ COLD WAR ☐ KOREA ☐ WW II ☐ WW I ☐

SERVICE: USA ☐ USAF ☐ USCG ☐ USMC ☐ USN ☐ CIV ☐ OTHER ☐

BRANCH: _____ RANK: _____

UNIT DESIGNATIONS AND DATES OF SERVICE: _____

_____

_____

I WOULD LIKE TO LOCATE (Names and Units): _____

_____

_____

MY ADDRESS: _____ PHONE ( ) _____

CITY: _____ STATE: _____ ZIP: _____

Please Mail to: BRAVO ★ P.O. Box 669 ★ Woodland Hills, CA. 91365

- STATEMENT OF JERRY HAWLEY -
ATTACHMENT #4

Introduction

The National Congress of American Indians needs to address a number of veterans issue's. This activity could be accomplised by performing the following obectives:

Ten Point Plan

Objectives:

1. Establish an NCAI Veterans Task force, (Provisional Body) to work in the best interest of Native American Veterans. The Provisional Body will be composed of Five (5) men and two (2) women who are Native American Veterans or spouse's of veterans who have a proven track record in veterans affairs and currently hold a position of important within a Native American Veterans organization (contemporary or traditional), must be a veterans, live and work within the native american communities, must not be employed by the Veterans Administration or be employed by any organization who serves Veterans. In addition, has never served on any type of advisory group to the veterans administration before Oct 3, 1989.

The committee will perform the following objectives:

1. Develop a comprehensive study concerning all Native American Veterans while developing a comprehensive Data Base Managment system for the storage and retrival of vital data. Data and information will be available to tribal and social/educational/health non-profit organizations through out Indian land.

2. Establish a National Veterans Office to serve as a national clearing house for Native Amercian Veterans, and develop a recruitment and retention programs for native american veterans into the vet centers and other programs designed to serve veterans, provide testimony and serve as consultants to the VA and other Government agencies, and tribal governments who serve Native Amercian Veterans.

3. Develop a National Service Officers training School to serve native american veterans, tribal government and other national Non Native American Service Officers who live within a high population of Native Americans. This school will allow for sensitivity training for our fellow veterans or VA employee/ counselor who donot have an understand of the unique relationship the native american veterans has with the U.S. Govenment. In addition, assist all tribal government with establishing a department of veterans affairs and to allocate funds for sponsoring two veterans to the service officers school and travel to the annual conference.

4. Coordinate and develop innovative programs to serve the needs of the veterans for Services and counseling of VA benefits

5. Coordinate referral and distribute information concerning service and legislative and social issues or activities concerning veterans between federal, tribal and other organizations who have a veterans target population. This format will allowing for the exchange of information and ideals for improving the communication network between the various organizations and the Native American Veterans.

6. Provide testimony on how to improving the outreach effort's of the Veteran Administration and National Veteran Service organization's while establishing a national dialog of interaction between various public & private organizations, such as the Department of Housing and Urban Development (HUD), Tribal Governments, Tribal Housing Authorities, Bureau of Indian Affair (BIA), Indian Health Service (IHS), U,S. Department of Commerce Bureau of the Census and other National non-profit entities such as private foundation that administer funds for Native Amercian Veterans.

7. Serve as an liasion between the Native Amercian Veterans, NCAI and Tribal organization and veteran organizations between Various Government & National Veterans Service organization including: the Veteran Administration, VA Indian working Group, National Vietnam Veterans Coalition (NVVC), Vietnam Veterans of America (VVA) Disabled American Veterans (DAV), Brotherhood Rally of Veterans Organization (BRAVO), American Ethnic Veterans of Vietnam,(AEVV) Inc., The Last Patrol and other veterans organizations.

8. Develop a Core of National Native American Counselors to serve remote areas on an as needed basis and to contract counseling service to the VA. This is needed due to the fact that the VA has only 4 native Amercian Veterans service as counselors.

9. Coordinate and Develop a National agenda concering pilot Programs with culture sensitivity to serve native american veterans, families and communities to address and meet the following needs:

PTSD and the Native American Family (counseling, Recruitment, retention and job placement)

VA Home Loan Program on Trust and Restricted Lands

Homeless & Incarcerated Native Amercian Veterans

Mental Health Issues

Veterans business loan program and Educational Opportunities

Employment opportunities and equal employment rights

Legislative Updates and recognition of Veterans

10. Develop a National Veterans Conference and have it funded by the VA with both logistic and printed matter for veterans, speakers and all related cost.

I would like to thank the NCAI and all the Veterans who provided input into this ten point plan of attack. In addition, a special thanks to the VEVITA. Thanks Bro's

Have

(2) objective

Have ~~the~~ tribes establish an ~~Office~~ Office of Veterans Affairs, To serve native American Veterans and also Provide funding for service dog school and Training for VA Benefits.

Veteran Minutes

Date: Oct 4, 1989
NCAI Conference
Oklahoma City, Ok

A presentation was made concerning the draft ten point plan that was presented to the group by Matthew Kauley.

Motion 1: To accept the Ten Point Plan as drafted with the Veterans Task force Board be identified as a provisional body with the composition of the board to be made up of 5 men and 2 women.

Motion by: Mike Haney
Seconded by:
Vote: Motion Passed

Motion 2: That the NCAI make Veterans Issuses a priority and that the administrative office assign a staff person and the president of the NCAI to work in conjunction with the Veterans task force board in making a native american a part of the Vietnam Veterans Memorial.

Motion 3: That the following people be seated as the new NCAI Veterans Task Force, As follows:

Matthew Kauley
Mike Haney
Jerry Riley
Margaret Riley
Edwin Chappabitty
Joe Cully
Juanita Learned

- STATEMENT OF JERRY HANLY -
ATTACHMENT 5

NATIVE AMERICAN VETERANS

VETERANS ADMINISTRATION ADVISORY COMMITTEE ON NATIVE AMERICAN VETERANS

FINAL REPORT

Raymond C. Field - Chairperson

February 1, 1988

TABLE OF CONTENTS

Page

PROLOGUE ii

ACKNOWLEDGEMENTS iii

EXECUTIVE SUMMARY v

I. REQUIREMENTS OF THE LAW 1

II. COMMITTEE ACTIVITY 1

III. FINDINGS 1
- a. Statement of the Problem 2
- b. Background to Problem 2
  - (1) VA Data Sources 2
  - (2) Other Federal Data Sources on Native Americans 2
- c. Recommendations 3
  - (1) Bureau of Census, Supplementary Questionnaire 3
  - (2) Indian Health Service 5
  - (3) National Medical Expenditure Survey 5
  - (4) VA Data Sources 5
- d. Statement of the Problem 6
- e. Background to Problem 6
- f. Reasons for Underutilizing VA Benefits and Services 7
  - (1) Geography 7
  - (2) Availability of Resources 7
  - (3) Culture 7
  - (4) Indian Health Service Eligibility 8
  - (5) Interagency Coordination 5
- g. VA and Indian Health Service 10
- h. Recommendations 11
  - (1) Socioeconomic Benefits 11
  - (2) Health Services 14

IV. CONCLUSIONS 15

APPENDICES

A. Albuquerque VA Medical Center: Program Considerations in Delivering Health Care to Indian Veterans
B. Report on Accessibility to Care
C. Traditional Healing
D. VA Loan Guaranty Program: Problems Associated with Reservation Land
E. Networking with Alcoholism Programs
F. Veterans Administration Advisory Committee on Native American Veterans

PROLOGUE

Throughout the course of American history the contribution of Indian warriors to the cause of peace has exceeded their political and economic representation in American society. They voluntarily have borne the scars of battle at a proportionately higher cost, and yet have not, as a people, received the recognition and honor which they so justly deserve.

These men and women represent a culture and tradition which promotes harmony between man and his spiritual, social and natural environments. The historic trust relationship between the Federal government and the Indian nations, when fully implemented, will insure that the sacrifices and forebearance of the Native American people in the cause of peace and in the continuing struggle for full participation in the mainstream of American life will not have been in vain.

The Committee membership included Indian veterans of World War II, Korea, and Vietnam who dedicated their efforts to doing the best possible job on behalf of our veterans. We hope that has been achieved. The non-Indian membership has been splendid in their attitude, ideas, commitment and support of the Committee's work.

We would be pleased with our efforts if the Indian warriors who did not return from World War II, Korea, and Vietnam would say, reviewing our work, "you people did OK."

ACKNOWLEDGEMENTS

The Committee wishes to extend its appreciation to VA officials at the Central Office and field levels and representatives of other agencies who worked tirelessly to produce a final report containing recommendations having a major impact on the organization and delivery of health, benefits, employment and training services to Native American veterans.

Our special appreciation is extended to the Administrator of Veterans Affairs, Mr. Thomas K. Turnage, for his unequivocal support of the VA Advisory Committee on Native American Veterans; his leadership in addressing the VA's responsibilities for responding to the needs of Native American veterans; and for his personal attention and sensitivity to the needs of Committee members, support staff and guests. The high priority accorded this Committee by the Administrator; Chief Medical Director, Dr. John A. Gronvall; Chief Benefits Director, R. J. Vogel; Acting Chief Memorial Affairs Director, Arthur S. Hamerschlag; the General Counsel, Donald L. Ivers, and other key staff has assisted Committee members from diverse backgrounds to develop a consensus on those issues and concerns which must be addressed in response to the Committee mandate. Our special thanks to Mr. John R. Fulton, Committee Manager, for his consultation, assistance and expertise in promoting Committee objectives and facilitating coordination with appropriate organizational elements within and outside of the VA; to Mr. Bruce D. Mobberley, Chief, Social Work Service, VA Medical Center Albuquerque, NM for his major role in compiling, editing and formatting the final report---the entire Committee stands and applauds Mr. Mobberley; to Mr. Edward M. O'Donnell for his administrative support and logistical assistance; to Mrs. Barbara Brandau, for sharing her experiential knowledge of the Federal advisory committee process; to Mrs. Helen C. Kowalski and Ms. Elois T. Lee for their secretarial assistance and special attention to those factors that contributed to the success of meetings and special events; to Dr. A. J. Singh, Director, Statistical Policy and Research Service, for his special work in statistics and data collection; to Mr. Herbert Mars, Deputy Director, Compensation and Pension Service, DVB, (Department of Veterans Benefits), for his ongoing consultation and assistance; and to Mr. Keith Pedigo, Director, Loan Guaranty Service, DVB for his stimulating presentation and discussion of relevant issues.

All Federal agencies with responsibilities and programs for serving Native Americans were invited to participate with the Committee in addressing interagency service requirements of Native American veterans. We acknowledge and thank officials of the Veterans Administration, Department of Labor, Department of Housing and Urban Development, Department of Health and Human Services (Indian Health Service), and the Department of Commerce (Bureau of Census). The single failure of the Federal Government to manifest interest or concern has been one department charged by Congress to be the most responsible for Indian concerns - the Department of Interior, and specifically, the Bureau of Indian Affairs. Despite invitations to participate with the Committee, the Bureau of Indian Affairs was conspicuous only by their disinterest and absence. Special thanks to Ms. Jennifer Vallie, Bureau of Census, for her assistance with statistical data; to Mr. Sam Apuna, Director, Health and Human Services, Office of Hawaiian Affairs, who provided consultation and assistance to the Committee concerning issues relevant to Native Hawaiian veterans; and to Dr. Everett Rhoades, Director, Indian Health Service, who firmly established his interest and participation with this Committee. We appreciate the generosity and hospitality of AMVETS and Disabled

American Veterans in hosting receptions for Committee members and key VA Central Office officials. Our special thanks to Mr. Andrew Montano, Director, VA Medical Center Albuquerque, NM, for providing logistical and secretarial support for the meeting in Albuquerque; and to Mr. Richard F. Murphy, Director, VA Regional Office, Seattle, WA, for making himself and his staff available to meet the needs of the Committee during our August meeting in Seattle. We wish to thank the Vietnam-Era Veterans Intertribal Association for the ongoing participation and support of this Committee.

We especially appreciate the attendance and participation of Native American veterans including tribal representatives at all Committee meetings. The presentation by Mr. Jackson Gibson, Assistant Director, Department of Veterans Affairs, Navajo Nation, was especially noteworthy. We also wish to thank Senator Frank Murkowski (R-AK), and Senator Thomas Daschle (D-S D) for their initiative in promoting the goals and objectives of this congressionally-mandated Committee.

A REPORT ON SERVICES TO THE NATIVE AMERICAN VETERAN BY THE VETERANS ADMINISTRATION

EXECUTIVE SUMMARY

Legislative Requirements

This report is in compliance with the requirements of Section 19032, Public Law 99-272, the Consolidated Omnibus Budget Reconciliation Act of 1986. The law requires the Administrator of the Veterans Administration to establish an Advisory Committee on Native American Veterans for the purpose of examining and evaluating programs and other activities of the Veterans Administration with respect to the needs of Native American veterans including American Indians and Alaska Natives. By legislative requirement the Committee's first report was submitted to the Administrator of Veterans Affairs February 1, 1987. This second and final report is to be submitted February 1, 1988, to the Administrator who will forward the report with comments and recommendations to the Committees on Veterans Affairs of the Senate and House of Representatives.

Findings

There were two major findings:

a. the lack of accurate and comprehensive statistical data on Native American veterans at local, regional, and national levels severely limits veteran identification, needs assessment, determination of utilization rates, and program planning. The VA does not routinely collect information on racial status and the Indian Health Service and Bureau of Indian Affairs do not routinely collect information on veterans status. The Bureau of Census and the National Medical Expenditure Survey represent the greatest potential source of information on Native American veterans.

b. the Native American veteran underutilizes VA benefits and health care services. The Native American compares unfavorably to the U.S. population on most socioeconomic and health status variables. Underutilization is related to several geographic factors such as distance and topography; unavailability of resources including transportation; cultural values; eligibility for Indian Health Service Programs; and the lack of coordination among federal agencies, especially between the Veterans Administration and the Indian Health Service.

Recommendations. The Committee's final report includes several recommendations which contain detailed descriptions of actions to be taken. These recommendations are abbreviated and listed according to VA responsibility for action versus interdepartmental responsibility and according to the general subject of the recommendation.

VA ACTION

Statistical Data:

1. That the Administrator arrange for VA access to statistical data gathered by other Federal agencies on Native American veterans and/or develop methods for collecting its own information on Native American veterans. Consideration should be given to reviewing the following non-VA data sources: Bureau of Census, Supplementary Questionnaire for American Indians; Indian Health Service Individual Application for Health Care Services; and the results of the National Medical Expenditure Survey. VA data sources including the Patient Treatment File, Annual Patient Census, Application for Medical Benefits, and all DVB claims forms should be included in the review.

2. Monies should be made available for persons with appropriate expertise to conduct research on Native American veterans. Of specific concern are:

a. demographic information

b. historical information

c. health and benefit needs

d. services utilization patterns

e. veterans' attitudes towards available Federal and tribal programs

f. cultural background

3. Monies should be made available for psychosocial research on Native American veterans.

Socioeconomic Benefits:

1. That the Administrator place a person qualified in Indian law, preferably a qualified Indian attorney, in the Office of General Counsel.

2. That the Administrator direct the employment of an additional 25 Native American veterans in offices such as Vietnam Era Veterans Outreach Centers serving significant numbers of Native American veterans in areas such as Alaska where Native American veterans are scattered over large geographical areas.

3. That the Administrator of the VA develop innovative methods of disseminating benefits information to veterans and their dependents residing on reservations including compensation and pension, veteran job training, education, vocational rehabilitation and death benefits.

4. That VA policy be modified as necessary to allow Adjudication Service, Department of Veterans Benefits, to accept and utilize medical summaries and records from Indian Health Service when rating benefit claims of Native American veterans.

26-623 - 90 - 4

5. That VA policy be modified or legislation amended to provide extended entitlement to veterans or other eligible persons who by reason of illness, including alcohol, drug dependency or addiction conditions were unable to complete education or training within the prescribed limits established by the Veterans Readjustment Benefits Act of 1966, as amended. This should also apply to all other education entitlement programs.

6. That the Administrator initiate a review of the VA Loan Guaranty Program for the purpose of identifying and resolving problems associated with Native American veterans receiving VA home loans (See Attachment D). Immediate action should be taken to:

a. Develop and publish guidelines setting out procedures to Native American veteran applicants seeking loans for housing on reservation or trust land housing.

b. Reimplement the VA Direct Home Loan Program for Native American veterans residing on reservations and/or trust land.

c. Encourage the development of Tribal Home Loan Programs.

d. Collaborate with interested tribes for the purpose of orienting/educating lending institutions to the effectiveness of tribal foreclosure mechanisms and the marketability of reservation housing.

Health Services:

1. That Vietnam Veterans Outreach Centers participate in outreach to Native American veterans.

2. That VA Medical Centers, Indian Health Service, Bureau of Indian Affairs, and local Native American Alcohol and Substance Abuse Programs collaborate to increase direct outreach services and aftercare for Native American veterans.

3. That VA Medical Center Directors consider alternative models of health care delivery including the use of traveling or satellite clinics and/or the use of contract services or sharing agreements.

4. That all VA direct service staff having frequent contact with Native American veterans be required to receive orientation/training in the culture and customs of Native American tribes in the local area. Such training will be provided by the VA RMEC (Regional Medical Education Center) utilizing American Indian or Alaska Native consultants and/or veterans presently employed by the VA.

5. Upon the request of the patient and/or family, VA Medical Center Directors will recognize the need for, and where appropriate, provide facility space to accommodate Native American traditional healing activities.

6. That the Veterans Administration approve and adequately fund a pilot project to be conducted at the Albuquerque VA Medical Center to determine the feasibility of utilizing Native American practitioners using fee basis dollars.

7. That a National Native American Veterans Coordinating Council be established with representatives from the Veterans Administration, Indian Health Service, Bureau of Indian Affairs, Department of Labor, Department of Housing and Urban Development and the Indian community for purposes of joint planning, establishing policy for interagency collaboration, developing legislative initiatives and facilitating field recommendations.

8. That the VA Administrator establish a special assistant position with appropriate staff to provide administrative support to the National Native American Veterans Coordinating Council.

9. That the VA Administrator develop an initiative for the establishment of Area Native American Veterans Coordinating Councils with representatives from IHS and BIA Area Offices, VA regional offices and VA medical centers in the area, Indian Health Boards and/or major IHS/BIA contractor providers for the purpose of administering and directing area-wide and local initiatives on behalf of Native American veterans.

10. That VA Medical Center Directors, when and where appropriate, establish local Indian Advisory Councils comprised of relevant interagency personnel for the purpose of identifying needs, developing policies and procedures for referral, and developing programs to meet the needs of Native American veterans.

11. That VA Medical Center Directors, when and where appropriate, enter into sharing agreements with the Indian Health Service and the Bureau of Indian Affairs for the purpose of maximizing the utilization of Federal resources and for meeting the health needs of Native American veterans.

Interdepartmental Action:

1. Recommend to Congress that GAO (General Accounting Office) conduct a study on how Federal funds designated to states are being utilized to assist Native American veterans.

2. It is recommended that the Bureau of Census utilize the Supplementary Questionnaire for American Indians for the 1990 Census.

3. That the Secretary, Department of Labor, place additional DVOP (Disabled Veterans Outreach Program) staff in the Office of the State Director for Veterans Employment and Training to work specifically with tribal entities.

4. That the Administrator develop a Task Force to include representatives from the Veterans Administration, Bureau of Indian Affairs, and Small Business Administration for the purpose of ensuring that Native American veteran businessmen residing on reservations or trust land have timely access to information on Federal contract opportunities.

5. That the Secretary, U.S. Department of Commerce:

A. Change the guidelines so that IBDC (Indian Business Development Centers) can cross state lines to serve Indian reservations and individual Indian people within logical geographical areas.

B. Consider adding IBDCs to cover Alaska, the Northwest Tribes, the Northern Plains Tribes, the Great Lakes Tribes, and Eastern Area Tribes.

6. That the Secretary, Department of Labor change the JTPA (Job Training Partnership Act) guidelines so that tribes may use such funds in enterprise development as well as for training and education.

7. That the Director, Office of Personnel Management, in collaboration with the Veterans Administration and Bureau of Indian Affairs develop personnel orientation and recruitment outreach programs to tribal reservations.

8. That Secretary, Department of Housing and Urban Development initiate the development of appropriate technologies on Native American veterans homes to facilitate energy conservation as a means of promoting community self-sufficiency.

9. The Director, Indian Health Service develop and implement procedures for ensuring that patient charts of veterans are clearly flagged "Veteran" and are referred to VA medical centers when IHS services are not available. A Sharing Agreement between IHS and VA Medical Center Directors should be negotiated.

I. REQUIREMENTS OF THE LAW

The Consolidated Omnibus Budget Reconciliation Act of 1986, Public Law 99-272, Section 19032, requires the Administrator of Veterans Affairs to establish a VA Advisory Committee on Native American veterans. The purpose of the Committee is to examine and evaluate programs and other activities of the Veterans Administration with respect to the needs of Native American veterans including American Indians and Alaska Natives. Membership of the Committee includes the Secretary of Labor, Chief Medical Director, Chief Benefits Director (or designees) and members appointed from the general public who represent American Indians and Alaska Natives. The Committee is to submit its first report of findings and recommendations not later than February 1, 1987, and its second and final report by February 1, 1988. Not later than 60 days after receiving each report the Administrator shall transmit to the Committee on Veterans' Affairs of the Senate and House of Representatives, a copy of the report, together with any comments and recommendations concerning the report that the Administrator considers appropriate. The Committee shall terminate 90 days after the date on which the second report is transmitted to the Administrator.

II. COMMITTEE ACTIVITY

The Committee held four meetings. The first meeting convened in Washington, DC, December 10-12, 1986, and resulted in a preliminary report to the VA Administrator on February 1, 1987. The second and third meetings were held in Albuquerque, NM, April 6-8 and Seattle, WA, August 4-6, for the purpose of obtaining broader representation from tribes and other relevant community groups. Numerous tribal and community agency representatives were invited to the Albuquerque and Seattle meetings and various officials representing VA and other Federal programs were invited to the Washington, DC, meetings. An additional reason for meeting in Albuquerque was to learn more about the experience of the Albuquerque VA Medical Center which had been involved in outreaching to Indian veterans for a year prior to the inception of the Advisory Committee. Exposure to the "Albuquerque Model" provided the Committee with valuable information on issues related to health care delivery and methods for improving Native American veteran access to VA health care. (See Attachment A)

The Committee was divided into three sub-committees in order to address issues, problems, and problem resolutions associated with the lack of statistical data on Native American veterans, the underutilization of VA benefits by Native American veterans, and the underutilization of VA health care facilities by Native American veterans. Sub-committee chairmen presented findings to the plenary group for comment, modification, and consensus.

III. FINDINGS

Two major problem areas related to VA service to Native American veterans were identified by the Committee: the lack of adequate statistical data on Native American veterans and the underutilization of VA benefits and health care services by this population. Numerous issues were discussed and recommendations were developed within these two major problem areas.

a. Statement of the Problem

The lack of accurate and comprehensive statistical data on Native American veterans at local, regional, and national levels severely limits veteran identification, needs assessment, determination of utilization rates, and program planning.

b. Background to Problem

The statistical data used by the Committee is derived from U.S. Census data and the scanty VA data that is available. There is no VA data on Native American veterans who do not utilize the VA. During the past few decades Federal law/policy has restricted the asking of direct questions on race when seeking services. VA health care data is derived primarily from VA Form 10-10, Application for Medical Benefits, the Annual Patient Census, and the Patient Treatment File. None of these forms accurately assess racial status. Claim forms used by the Department of Veteran Benefits are numerous and vary with the type of claim being submitted and none identify racial status.

(1) VA Data Sources.

(a) Application for Medical Benefits, VA Form 10-10. This is a form that must be completed on veterans receiving care from a VA medical facility. It does not include questions on race nor does it reference Indian Health Service eligibility for Native American veterans.

(b) Annual Patient Census. The Medical Staff Worksheet 1987 Census VA Form 10-797d(Test). Racial status is recorded but the question is not asked of the patient. The census form is completed by clinical staff who may subjectively determine the race of the patient based on surnames and/or stereotypic views of racial features. Use of surnames to determine race would be particularly misleading in the Southwest where many American Indians have Hispanic surnames. The Annual Patient Census does not include patients on outpatient status.

(c) Patient Treatment File (PTF). The PTF is used to collect data on all patients discharged from VA medical centers and represents a major source of information in the Veterans Administration. The information collected is obtained from medical discharge summaries prepared by the patient's physician. Information to be included in the summary is based on MP-6, Part XVI, which asks questions on race, i.e., American Indian and Alaska Native. As with the Annual Patient Census, the question is not answered by the patient but by the patient's physician. Again, racial determinations based on surnames or stereotypic views of racial features can be misleading. The PTF does not include information on outpatients.

(2) Other Federal Data Sources on Native Americans.

(a) Bureau of Census, Department of Commerce. Supplementary Questionnaire for American Indians, Form D-15, was utilized by the 1980 census and implies a data bank on Native Americans. In addition to questions on education, employment and income the

Supplementary Questionnaire for American Indians asks several questions on medical/dental services including where services were received, how long it took the person to travel to the medical facility, and who paid the bill. It does not include questions on veteran status. If modified to include questions on veteran identification, the Supplementary Questionnaire offers the potential of systematically updating data on Native American veterans residing on reservations or historic areas of Oklahoma. With the modifications suggested, it is important that the Supplementary Questionnaire be used for the 1990 census.

(b) Indian Health Services. The Native American veteran may be eligible for both VA and IHS services. It is assumed that most veterans residing on reservation receive their primary and secondary care from IHS. Historically IHS (and BIA) have not included questions on veteran status on their application for care forms. Including veterans status questions would not only assist the VA in identifying Native American veterans but would assist the IHS in ensuring a cost effective contract health program since contract health is not an entitlement program and all other resources must be reviewed.

(c) National Medical Expenditure Survey. The National Center for Health Services Research and Health Care Technology Assessment, Department of Health and Human Services, and the Health Care Financing Administration have developed several questionnaires for the purpose of surveying American Indians and Alaska Natives; OMB survey instrument 0937-0162 expired 12/31/87. IHS is funding a survey of Native Americans as part of a larger effort to determine national medical expenditures. The survey questionnaires pertaining to American Indian and Alaska Natives ask numerous indepth questions related to the subject of hospital stay (inpatient); health conditions; outpatient visits; emergency room care; prescribed medicine; other medical expenses; dental care; and home health services. All questionnaires contain questions on VA services indicating name of facility where care was received and questions on whether VA paid for or provided the service. Information obtained from the surveys and used in conjunction with 1980 or 1990 census data could provide important information on Native American veterans who have used or not used the VA. VA statistical data is based primarily on veteran utilization of VA facilities and does not address the veteran population that does not utilize the VA.

c. Recommendations

That the VA Administrator arrange for VA access to statistical data gathered by other Federal agencies on Native American veterans and/or develop methods for collecting its own information on Native American veterans. Consideration should be given to reviewing the following data sources:

(1) Bureau of Census, Supplementary Questionnaire for American Indians, Form D-15. It is recommended that this questionnaire be utilized for the 1990 Census with the following modification:

(a) Questions 18 and 19 on the Supplementary Questionnaire should be modified to address VA usage.

Question 18. During the last 12 months, where did this person usually seek health care?

Add, VA Hospital or Clinic.

Question 19. During the last 12 months, how was this person s health care paid for?

Add, Received from the VA.

(b) An additional question, with several parts, needs to be added to the Supplementary Questionnaire pertaining to veterans status.

Question 30a. Are you a veteran of any branch of the United States Armed Forces?

1___Yes
2___No

Question 30b. If yes, which one?

1___Army
2___Navy
3___Air Force
4___Marines
5___Coast Guard

Question 30c. If yes, during which era did you serve?

1___World War I
2___Between World War I and World War II
3___World War II
4___Between World War II and Korea
5___During Korean Conflict
6___Between Korea and Vietnam
7___During Vietnam
8___After 1975

(c) The following questions should be added to both the Primary and Supplementary Questionnaires:

Question 31a. Did you receive any veterans benefits during the past year?

1___Yes
2___No

Question 31b. Educational Benefits

1___Yes
2___No

4

Question 31c. Disability Benefits

1___Yes
2___No

If yes, indicate percent disabled, 10, 20, 30...___%

Question 31d. Death Benefits

1___Yes
2___No

Question 31e. Nonservice-Connected Pension

1___Yes
2___No

Question 31f. Home Loan Benefits

1___Yes
2___No

(2) Indian Health Service. Questions on veteran status need to be included on IHS Form 1A0-21, Rev. 5-84, Individual Application for Health Care Services and be inserted after question 45.

Are you a veteran?

1___Yes
2___No

Dates of Service: _____
Claim Number (if available) _____

(3) National Medical Expenditure Survey. In addition to providing indepth information on Native American health care including veterans, this survey could provide valuable information on Native American veterans who do not use the Veterans Administration. It is strongly recommended that the VA obtain access to Native American veteran data gathered by this Survey.

(4) VA Data Sources. All claims forms used by the VA Department of Veterans Benefits and Application for Health Care forms used by the VA DM&S (Department of Medicine and Surgery) plus the DM&S Annual Patient Census and Patient Treatment File questionnaires should be reviewed and modified as necessary to provide information on racial status.

(5) The Director, Indian Health Service should develop and implement procedures for ensuring that the patient charts of veterans are clearly flagged "Veteran" and are referred to VA medical centers when IHS services are not available. A Sharing Agreement between IHS and VA Medical Center Directors should be negotiated.

(6) Monies should be made available for persons with appropriate expertise to conduct research on Native American veterans. Of specific concern are:

(a) demographic information

(b) historical information

(c) health and benefit needs

(d) services utilization patterns

(e) veterans' attitudes towards available Federal and tribal programs

(f) cultural background

(7) Monies should be made available for psychosocial research on Native American veterans.

d. Statement of the Problem.

Native American veterans are underutilizing VA benefits and health care services.

It is acknowledged that there is little data on the utilization of VA benefits and health services by Native American veterans. Nevertheless, the overwhelming consensus of Committee members is that Native American veterans significantly underutilize VA programs. This belief is based on the personal experience of Committee members, knowledge of their own Native American communities, and the observations of VA staff at local regional offices and health care facilities. Existing VA data supports the contention of underutilization at least in so far as VA health care is concerned. Native American veterans comprise 0.6% of the total living veteran population. There are 1.7 million Native Americans in the United States, 159,900 are veterans. In FY 85, data derived from the VA Patient Treatment File and Annual Patient Census indicates 0.4% of hospital discharges and 0.3% of hospitalized patients were Native American. VA medical centers in the Midwest, West, and Southwest accounted for 85% of all Native American veterans discharged during FY 85.

e. Background to Problem

Historically, there has been little effort by the VA to target the Native American veteran population as a unique population requiring special attention. Approximately 40 to 50% of Native Americans live on reservations located in remote rural areas which limits the understanding Native American communities have of VA benefits and health services. In regard to health care, reservation Native Americans, including veterans, have eligibility for Indian Health Service. Knowledge of this dual eligibility coupled with the remoteness of a large percentage of the population resulted in a type of benign neglect by the VA. In addition, incentive to outreach Native American veterans for the purpose of improving access to health care was minimal prior to 1984 due to the VA

funding model. Many, if not most, VA medical facilities turned away nonservice-connected veterans prior to 1984 due to lack of funding. Within this context little attention was given to outreaching any population. The revised eligibility criteria and resource allocation methodology provide a method of reimbursement for services provided to low income, nonservice-connected veterans thus enhancing the potential for outreach efforts.

f. Reasons for Underutilizing VA Benefits and Health Care Services.

(1) Geography. Appendix B, Report on Accessibility to Care, includes several maps which clearly demonstrate the remote locations of the Native American population in the U.S., the county population centers located over 100 miles from the nearest VA medical center or outpatient clinics, and the counties that are considered to be medically underserved. There is a high correlation among the location of Native Americans, considerable distance to VA medical centers, and counties that are considered medically underserved. It should be noted that the distance is expressed in air miles and is limited to 371 counties in the U.S. with population centers over 100 miles from VA facilities. Distance data does not address such issues as topography, weather, road miles, availability of transportation, nor the distinctive remote barriers in Alaska. All of these geographic variables impinge on Native American veteran accessibility to VA benefits and health care services.

(2) Availability of Resources. Utilization of VA benefits and health care services is also contingent upon the availability of transportation, the financial ability to use same, and the age and health status of the veteran. Many rural areas are without air or bus services, thus private automobiles are required. Currently VA beneficiary travel policy in DM&S excludes payment for the first 100 miles (200 miles round trip) which means the patient must assume this cost himself. Also there is the issue of having to pay for food and lodging for himself and/or a driver should an overnight stay be required. In general, the Native American population is an economically deprived population and Native Americans living on reservations are the most deprived. Many reservations have unemployment rates that exceed 50%. This population does not have the means to travel long distances to seek VA benefits or health care.

(3) Culture. Another reason to be considered for the underutilization of VA health service is culture. Native American culture(s) frequently differ from the dominant culture in terms of language, understanding, and expectations. Attitudes toward illness and disease may vary and shape a person's decision to seek care and/or accept the care offered. Many Native Americans place great value on indigenous healing systems and seek a blending of traditional healing and western medicine. Given the large number of tribes and their differences in language and traditional belief it is extremely difficult to define traditional healing. It can be said that traditional healing delicately balances religion, spirituality, and medicines derived from the natural surroundings to the treatment and healing process. Although rarely understood or appreciated by modern medicine or the general population, traditional healing is real, valid, and sacred to those who participate in the traditional way of life.

Negative perceptions of the VA by Native American veterans affect the utilization of benefits and health services. It is the viewpoint of many Native American veterans that they would not be understood or accepted by VA staff. Conversely, it is the perception of some VA staff that it is difficult to provide health care services to Native American veterans. VA providers and medical center directors need to be cognizant of, and sensitive to, the cultural differences that impact utilization of VA services. (See Appendix B.)

(4) Indian Health Service Eligibility. The underutilization of VA health care facilities by Native American veterans may be explained by their use of Indian Health Service facilities. Of the 1.7 million Native Americans in the U.S., approximately 1,000,000 are eligible for health services provided by the Indian Health Service. Effective September 16, 1988, eligibility for both direct and contract health services require membership in a federally-recognized tribe and residency within a designated service area. Most Native Americans, including veterans, would be eligible for both primary and secondary care at available Indian Health Service facilities. Indian Health Service provides no direct tertiary care services choosing, to the extent such services may be within medical priorities, to contract out these services for eligible patients. Indian Health Service is not an entitlement program; all other resources (private insurance, state and local programs, medicare, medicaid, VA) must be utilized before contract health services can be used. In California all IHS services are administered by tribes or tribal organizations and all services that cannot be provided by the outpatient clinics must be provided through contract. Native American veterans requiring tertiary care services at IHS facilities should be automatically screened for VA eligibility and referral; however, Indian Health Service has not normally captured veteran status data in their registration forms nor are patient charts clearly marked "veteran" so as to alert Indian Health Service physicians to the possibility of a VA referral in the event there is need for tertiary care. Despite the various Indian Health Service eligibility restrictions, it may be assumed that large numbers, if not the majority of Native American veterans, especially those residing on or near reservations, have their health needs met at Indian Health Service facilities. Those that live outside a CHSDA (Contract Health Services Delivery Area) are currently eligible for direct primary and secondary care services if an Indian Health Service facility is available. They typically would not be eligible for tertiary care services that require contracting with non-IHS facilities. California, which contains the largest census identified Native American population in the country, does not have any IHS operated hospitals or clinics, nor does the Los Angeles-Long Beach area, which contains the largest urban Native American population in the country. Whereas it may be assumed that Native American veterans living on or near reservations utilize IHS facilities, there are serious questions regarding where the urban Native American veteran seeks care.

(5) Interagency Coordination. Although geography, availability of resources, culture, and eligibility for IHS services are significant variables in explaining the underutilization of VA benefits and services by Native American veterans, the lack of interagency corrdination among Federal, state and tribal agencies perhaps represents the greatest

obstacle to the delivery of needed benefits and services to the Native American veteran. The Veterans Administration, the Indian Health Service, the Bureau of Indian Affairs, the Department of Housing and Urban Development and the Department of Labor represent the major Federal agencies that have some responsibility for the Native American veteran. In addition most states in the Midwest, West and Southwest would have an "Office of Indian Affairs" and have responsibility for providing services to Native Americans, including those that are veterans. Finally, tribal governments have responsibility for their constituents. The need for these agencies to work collaboratively is essential if utilization of resources are to be maximized and if the Native American veteran is to receive those benefits and services for which he is eligible and so badly in need.

Despite general improvement over the past few years the Native American population continues to compare unfavorably on most socioeconomic and health variables. In 1980, 27.5% of American Indians had incomes below the poverty level compared to 12.4% of the total U.S. population. For the same period, 40.2% of New Mexico Indians were on or below the poverty level. The unemployment rate for Indians was twice that of the total population and many reservations have unemployment rates upward of 50%. The VA Office of Information in 1980 indicated slightly more than 67% of Native American veterans were actually employed. Of those that held jobs, 38% worked less than 50 weeks of the year. There is considerable evidence that Native Americans, especially those residing on reservations, are economically deprived.

Native Americans are in poor health compared to the rest of the U.S. The most significant indication is that Native Americans do not live as long as other U.S. populations. Indian death rates 1980-82 exceed national averages for accidents, liver disease/cirrhosis, pneumonia/influenza, diabetes, homicide, suicide, nephritis, septicemia, tuberculosis and all causes. Age specific death rates for New Mexico Indians demonstrate this remarkably. Examples include the age category 25-44 for males, which shows a death rate due to cirrhosis to be six times the U.S. rate, five times the U.S. average for all accidents, and three times the U.S. rate for suicide. For the New Mexico Indian male population in age category 45-65, the death rate for all accidents is six times the U.S. average, four times for diabetes, and twice the rate for cirrhosis.

It is within the context of socioeconomic deprivation and multiple health needs that Native American veterans should be made aware of, and receive, VA benefits and services for which they are eligible. The VA provides a full range of benefits for eligible veterans and dependents which includes compensation and pension, education and training, vocational rehabilitation, guaranteed home loans, death benefits, life insurance and numerous other benefits for the service-connected disabled. Native American veterans living on reservations remote from VA regional offices and receiving medical care through Indian Health Service are conceivably without contact with VA personnel and therefore without knowledge of VA benefits and services that are available. There is also a lack of knowledge among IHS personnel regarding the benefits and services offered by the VA.

In addition to VA benefits there are numerous Federal benefits and services that are available to veterans which are not administered by the VA and which may be unknown to those living in remote, reservation areas. A partial list of these programs include: job finding assistance; unemployment compensation for ex-service personnel; the Job Training Partnership Act; Disabled Veterans Outreach Programs; FHA Home Mortgage Insurance; and programs of the Small Business Administration. There are Federal programs having potential for benefiting minority populations and although not specific to veterans, the Native American population could benefit from them. Examples include Affirmative Action Programs, the Small Business Administration, the Minority Business Development Agency, and various legislative acts aimed at ensuring minority owned businesses receive a proportionate share of Federal contracts. An example of the latter are the contract goals for minorities as established by Congress for DOD (Department of Defense) contracts and cited in the Congressional Record, October 14, 1986. Attempts to address the economic needs of the Native American veteran requires collaboration among various Federal agencies in identifying, modifying as necessary, and creatively implementing personnel management and economic programs. It has been well documented since World War II that the minimal investment the Federal Government has made in providing benefits to veterans such as the various GI Bills and programs encouraging home ownership has been returned multifold in economic benefits to the nation. Addressing the needs of Native American veterans would not require special appropriations of funds and would produce economic benefits in reducing Social Welfare expenditures and providing an opportunity for Indian veterans to contribute as assets of a country at peace. In general, any effort to create job opportunities on reservations will ultimately benefit Indian veterans, as well as the overall population, and therefore should be encouraged by the VA. Disseminating information pertaining to VA and other Federal benefits programs to veterans living in rural or remote areas is a necessary function of the respective agencies.

It is acknowledged that the administration of various veterans benefits programs is complicated when applied to veterans residing and wishing to continue to reside on reservations. A notable example is the VA Loan Guarantee Program. This program has provided significant benefit to veterans throughout the nation but has been unavailable to Native American veterans living on reservation or trust lands. Issues associated with the impasse relate to the ability of the Indian applicant to obtain title to the land, the assignability of leasehold interests, problems associated with foreclosure and the marketability of the land in the case of default. Although difficult, the problem does not appear to be insoluble and efforts to resolve the impasse need to be pursued. (See Appendix D) There may be other programs which are difficult to implement on reservations; however, it is necessary for the responsible agency to pursue solutions rather than to ignore the problems.

g. VA and Indian Health Service Collaboration

In addition to the need for multi-agency coordination and cooperation in addressing the socioeconomic status of the Native American veteran, there is the same need for collaboration between the VA and Indian Health Service in regard to the health status of the Native American veteran. The Veterans Administration and the Indian Health Service

represent two federal health care delivery systems mandated by Congress to address the health care needs of eligible veterans and eligible Native Americans. There is overlapping responsibility for the Native American veteran. Aside from the obvious need to collaborate on behalf of the Native American veteran, collaboration between the two agencies has the potential for meeting the Congressional mandates of the two agencies in a cost effective manner. The VA has medical facilities distributed in most urban areas in the U.S., including those with the largest Native American populations. Conversely, the Indian Health Service operates direct, primary and secondary facilities in many rural areas in the Midwest, West, and Southwest where the VA is without presence. Interagency collaboration obtained through sharing agreements might further the Congressional mandates and better service the urban and rural Native American veteran. It is essential that the VA and IHS develop a sound working relationship. Regular and frequent communication between the two agencies and other relevant federal, state, and tribal agencies at local, regional, and national levels would facilitate joint planning, minimize duplication of service, maximize use of federal and state resources, and result in cost savings. The Indian Advisory Committee established at VAMC, Albuquerque has served as an extremely valuable mechanism for systematic interagency communication/coordination at the operational level and may well serve as a model for other medical centers. The arrangement that has been developed between the Albuquerque VA Medical Center and the All Indian Pueblo Council regarding the referral of tribally committed veterans to the VA s Inpatient Alcohol Program is an example of a collaborative effort (See Appendix E). Interagency coordinating mechanisms are also needed at the regional and national levels. A three-tiered level of interconnecting coordinating councils is needed to facilitate timely decision making and promote interagency collaboration. The area/regional coordinating councils could be organized around the eleven Indian Health Service areas and include representatives from IHS, BIA, State Office of Veterans Affairs, Area Tribal Leaders, major IHS contract providers, and VA medical centers and regional offices. The composition of a National Coordinating Council would include the top officials/designees of the same agencies but in addition include representatives from the Department of Labor and the Department of Housing and Urban Development. (See Appendix B for composition, function, and suggested locations.)

h. Recommendations

(1) Socioeconomic Benefits.

(a) That the Administrator place a person qualified in Indian law, preferably a qualified Indian attorney, in the Office of General Counsel.

(b) That the Administrator direct the employment of an additional 25 Native American veterans in offices such as Vietnam Era Veterans Outreach Centers serving significant numbers of Native American veterans in areas such as Alaska, where Native American veterans are scattered over large geographical areas.

(c) That the Director, Office of Personnel Management, in collaboration with the Veterans Administration and Bureau of Indian Affairs develop personnel orientation and recruitment outreach programs to tribal reservations. Outreach activity should consider but not be limited to:

1. Disseminating information on the Federal employment application process through the use of workshops, job fairs, and distribution of written material.

2. Developing methods for informing tribal offices of Federal job vacancies.

3. Developing methods for informing potential employers of the benefits of the Veterans Job Tax Credit Program.

4. Actively participating in "career days" at reservation high schools and at VA medical centers for the purpose of familiarizing students to various health occupations.

(d) That the Secretary, U. S. Department of Commerce:

1. Change the guidelines so that Indian Business Development Centers (IBDC) can cross state lines to serve Indian reservations and individual Indian people within logical geographical areas.

2. Consider adding IBDCs to cover Alaska, the Northwest Tribes, the Northern Plains Tribes, the Great Lakes Tribes, and Eastern Area Tribes.

(e) That the Secretary, Department of Labor change the Job Training Partnership Act (JTPA) guidelines so that tribes may use such funds in enterprise development as well as for training and education.

(f) That the Secretary, Department of Labor, place additional DVOP (Disabled Veterans Outreach Program) staff in the Office of the State Director for Veterans Employment and Training to work specifically with tribal entities.

(g) That the Administrator develop a Task Force to include representatives from the Veterans Administration, Bureau of Indian Affairs, and Small Business Administration for the purpose of ensuring that Native American veteran businessmen residing on reservations or trust land have timely access to information of Federal contract opportunities. The Task Force should review:

1. U.S. Government policy and procedures related to procurement invitations, contract awards, and sub-contracting leads.

2. The use and value of the CBD (Commerce Business Daily) by Native American veteran businesses located on reservation and trust lands.

3. The procedures used by VA medical centers for soliciting bids on contracts under $10,000.00.

4. The methods used by the VA and BIA for determining the identity of qualified Native American reservation businesses interested in Federal bids.

5. The feasibility of having the Small Business Administration establish a special program for achieving 8(a) Certification for Native Americans, especially Native American veterans.

6. Establishing methods for disseminating information to reservation businessmen regarding Federal contract opportunities with specific reference to the SBA/DOD Agreement ("nickel defense") cited in Section 1207, Contract Goals for Minorities, Congressional Record; October 14, 1986, Part III, page H10190.

(h) That the Administrator of the VA develop innovative methods of disseminating benefits information to veterans and their dependents residing on reservations including compensation and pension, veteran job training, education, vocational rehabilitation and death benefits.

(i) That Vietnam Veterans Outreach Centers participate in outreach to Native American Veterans.

j. That VA policy be modified as necessary to allow Adjudication Service, Department of Veterans Benefits, to accept and utilize medical summaries and records from Indian Health Service when rating Native American veterans.

(k) That VA policy be modified or legislation amended to provide extended entitlement to veterans or other eligible persons who by reason of illness, including alcohol, drug dependency, addiction or abuse were unable to complete education or training within the prescribed limits established by the Veterans Readjustment Benefits Act of 1966, as amended. This should also apply to all other education entitlement programs.

(l) That the Secretary of the Department of Housing and Urban Development initiate the development of appropriate technologies on Native American veterans' homes to facilitate energy conservation as a means of promoting community self-sufficiency.

(m) That the Administrator initiate a review of the VA Loan Guarantee Program for the purpose of identifying and resolving problems associated with Native American veterans receiving VA home loans. (See Appendix D) Immediate action should be taken to:

1. Develop and publish guidelines setting out procedures to Native American applicants seeking loans for housing on reservation or trust land housing.

2. Reimplement the VA Direct Home Loan Program for Native American veterans residing on reservation or trust lands.

3. Encourage the development of Tribal Home Loan Programs.

4. Collaborate with interested tribes for the purpose of orienting/educating lending institutions to the effectiveness of tribal foreclosure mechanisms and the marketability of reservation housing.

(2) Health Services

(a) That VA medical centers, Indian Health Service, Bureau of Indian Affairs, and local Native American Alcohol and Substance Abuse Programs collaborate to increase outreach, direct services, and aftercare for Native American veterans.

(b) That VA Medical Center Directors consider alternative models of health care delivery including the use of traveling or satellite clinics and/or the use of contract services or sharing agreements.

(c) That all VA direct service staff having frequent contact with Native American veterans be required to receive orientation/training in the culture and customs of Native American tribes in their local area. Such training will be provided by the VA Regional Medical Education Centers (RMEC) utilizing American Indian or Alaska Native consultants and/or veterans presently employed by the VA.

(d) Upon the request of the patient and/or family, VA Medical Center Directors will recognize the need for, and where appropriate, provide facility space to accommodate Native American traditional healing activities. (See Appendix C)

(e) That the Veterans Administration approve and adequately fund a pilot project to be conducted at the Albuquerque VA Medical Center to determine the feasibility of utilizing Native American practitioners using fee basis funds.

(f) That a National Native American Veterans Coordinating Council be established with representatives from the VA, IHS, BIA, Department of Labor, Department of HUD and the Indian community for the purpose of joint planning, establishing policy for interagency collaboration, developing legislative initiatives and facilitating field recommendations.

(g) That the VA Administrator establish a special assistant position with appropriate staff to provide administrative support to the National Native American Veterans Coordinating Council.

(h) That the VA Administrator develop an initiative for the establishment of Area Native American Veterans Coordinating Councils with representatives from IHS and BIA Area Offices, VA Regional Offices and VA Medical Centers in the area, Indian Health Boards and/or major IHS/BIA contract providers for the purpose of administering and directing area-wide and local initiatives on behalf of Native American veterans.

(i) That VA Medical Center Directors, when and where appropriate, establish local Indian Advisory Councils comprised of relevant interagency personnel for the purpose of identifying needs, developing policies and procedures for referral, and developing programs to meet the needs of Native American veterans.

(j) That VA Medical Center Directors, when and where appropriate, enter into sharing agreements with the Indian Health Service and the Bureau of Indian Affairs for the purpose of maximizing the utilization of Federal resources and for meeting the health needs of Native American veterans.

(k) Recommend to Congress that GAO conduct a study on how Federal funds designated to states are being utilized to assist Native American veterans.

IV. CONCLUSIONS

The Native American veteran has served his country well throughout the several wars and conflicts in this century. The numerous benefits bestowed upon our Nation's veterans by a grateful citizenry have not reached every corner of the Land. Those veterans residing in rural or remote areas are at a distinct disadvantage in fully utilizing VA benefits and health care services even though they might well have the greatest need. VA studies have indicated that 97.1% of all veterans live within a 100 mile radius of a VA medical facility. A large part of the remaining 2.9% are obviously residents of reservations which are usually at a considerable distance from a VA presence. This is surely a population in need. The veteran living on a reservation is usually faced with unemployment, poverty, and a shorter life span. The Veterans Administration and other Federal agencies have the responsibility to address the unique needs of this veteran population and must develop a pro-active approach to problem solving. The members of the VA Advisory Committee on Native American Veterans appreciate the opportunity to participate in this worthy endeavor and believe the implementation of their recommendations will make a difference.

APPENDIX A

ALBUQUERQUE VA MEDICAL CENTER: PROGRAM CONSIDERATIONS IN DELIVERING HEALTH CARE TO INDIAN VETERANS

ANDREW MONTANO
Director
VA Medical Center
Albuquerque, New Mexico

BRUCE D. MOBBERLEY
Chief, Social Work Service
VA Medical Center
Albuquerque, New Mexico

May 13, 1987

TABLE OF CONTENTS

Page

I. BACKGROUND 1

II. SOCIOECONOMIC AND HEALTH STATUS 1

III. BARRIERS TO CARE 2

IV. THE ROLE OF THE INDIAN HEALTH SERVICE 2
a. On Reservation 3
(1) Direct Service 3
(2) Contract Health Services 3
b. Off Reservation 3
(1) Direct Service 4
(2) Contract Health Services 4
(3) Urban Indian Health Program 4

V. THE ROLE OF THE VA IN MEETING THE NEEDS OF INDIAN VETERANS 4
a. Health Services 4
b. Veterans Benefits 5

VI. FEDERAL HOSPITAL SYSTEMS SHARING ACT - PUBLIC LAW 97-142 5
a. Contract Health Services 6
b. Direct Services 6

VII. AVAMC INDIAN VETERAN OUTREACH EFFORTS 7
a. Gallup Outreach Program 7
b. Indian Advisory Committee 8
c. VA-IHS Veterans Outreach Program 9

VIII. SUMMARY 10

I. BACKGROUND

The AVAMC (Albuqerque VA Medical Center) is the only VA Medical Center in New Mexico and has a primary service area of 121,000 square miles, plus the 25,000 square mile Navajo Nation, most of which is in Arizona. The population is sparsely distributed and tri-cultural: Anglo 53 percent; Hispanic 36 percent; Indian 8 percent; and compares unfavorably to national averages on poverty, per capita income, education, mortality rates, and other health status variables. Distance, topography, lack of transportation, economics, culture, and language serve as formidable barriers to VA health care access. Many New Mexico veterans are deprived of much needed VA benefits and services as a result of these barriers. A major consideration of the AVAMC is the development of methods to enhance access to VA health care.

The Veterans Health Care Act of 1984, Public Law 98-528, required the Administrator to report to Congress on VA health care in remote areas. A finding of that study indicated 97 percent of all veterans live within a 100 mile radius of a VA medical facility. An assumption can be made that veterans in the Southwest comprise a significant part of the 3 percent beyond 100 miles, and in particular Native American veterans living on reservations are singularly disadvantaged. New Mexico ranks fourth in the nation on size of Indian population. Arizona, which ranks third, contains most of the square miles of the Navajo tribe which is the largest tribe in the United States. The Navajo Nation is in the AVAMC primary service area. A conservative estimate of the Indian population in the primary service area is 255,000 which excludes Hopi land. The population represents 19 pueblo tribes, the Mescalero and Jicarilla Apache reservations, and the Navajo Nation. A large number of Indians live in urban areas. The Albuquerque Urban IHC (Indian Health Center) estimates there to be over 25,000 Indians residing in Albuquerque and although most are Navajo, some 163 tribes have been identified.

There is little statistical information available on the Native American veteran. The VA Advisory Committee on Native American Veterans, established by PL 98-272, has identified this as a major problem in VA planning efforts. Information that is available is derived primarily from the U.S. Census Bureau. Questions on race/ethnicity are not routinely included on VA applications for benefits and services, nor are questions on veteran status included on application forms administered by the IHS (Indian Health Service), Bureau of Indian Affairs, or the tribes. Most of the available information pertains to Native Americans in general from which inferences are drawn about the Native American veteran.

II. SOCIOECONOMIC AND HEALTH STATUS

The following information offered is not comprehensive nor definitive, but is reflective of some of the needs of the Indian veteran. However, the health care needs of Native Americans in general have been well documented, and it should be noted that the potential exists to bring health care delivery to this population through collaborative efforts between the Veterans Administration and other agencies such as the IHS. The 1980 Census indicated that one third of all Native Americans are on or below the poverty level, which is twice the national average. For the same period, 40.2 percent of New

Mexico Indians were at or below the poverty level, which was approximately two and one-half times the state average. Unemployment rates for Native Americans in 1980 were 13 percent, which was twice the national rate of 6.5 percent. Reservation unemployment was 27.8 percent in 1980 and represents a major reason for leaving the reservation. A clarion cry for "jobs" is expressed by tribal leaders as unemployment reaches upward of 50 percent on some reservations. According to the VA Office of Information, in 1980 slightly more than 67 percent of Native American veterans were actually employed. Of those that held jobs, 38 percent worked less than 50 weeks of the year.

Native American mortality rates on many health-related variables far exceed the national averages: heart disease, cerebrovascular disease, pneumonia, diabetes, cirrhosis, suicide, homicide, and alcoholism. Age-specific death rates for New Mexico Indians demonstrate this remarkably. Examples include the age category 25-44 for males, which shows a death rate due to cirrhosis to be six times the U.S. average, fives times the U.S. average for all accidents, and three times the U.S. average for suicide. For the Indian male population in age category 45-65, the death rate for all accidents is six times the U.S. average, four times for diabetes and twice the rate for cirrhosis. The mortality rates of New Mexico Indians exceed national rates for most leading causes of death.

III. BARRIERS TO CARE

The evidence clearly indicates that Native Americans compare unfavorably to U.S. averages on various socioeconomic and health-related variables, and this is supported by data for the Indian population of New Mexico. There are many barriers that prevent the Indian veteran from accessing VA benefits and health services. Distance, remoteness, and lack of transportation have particular significance. Methods for reducing these barriers are obviously needed. Historically there have been few efforts by the Department of Medicine and Surgery and the AVAMC to target the Native American veteran population as a group requiring special attention. The rural location of the population coupled with eligibility for Indian Health Services resulted in an out-of-sight, out-of-mind phenomenon. An additional extremely important reason for not providing the outreach services necessary to improve access for the Native American veteran prior to 1984 was the VA funding formula. Due to lack of funding, many VA medical centers were turning away the nonservice-connected veterans who were able to get to the medical center. Within this context outreach activities had to be minimized. The current VA Resource Allocation Model provides a method of reimbursement for the nonservice-connected veteran, thus enhancing the potential of outreach activities.

IV. THE ROLE OF THE INDIAN HEALTH SERVICE

During planning efforts at AVAMC to outreach the Indian veteran, it became evident that Indian Health Service was probably providing most of the health care that Indian veterans received. This was particularly true for the reservation Indian veteran. Although no statistics were available, the consensus of staff observations was that few veterans of Indian origin received treatment at AVAMC. Health planning for Indian veterans requires

a general understanding of IHS organization, the services that are offered, and the eligibility requirements for services.

Organizationally the Indian Health Service is divided into 11 geographic areas, each with its own Area Director. There are two area offices within the PSA of AVAMC: Albuquerque Area, which serves all of New Mexico; and the Window Rock, Arizona Area, which serves the Navajo Nation. Hopi land is served by the Phoenix Area office. IHS serves the "recognized" tribes in the U.S. through the provision of direct services and contract health services. IHS direct services include primary and secondary care delivered at IHS medical care facilities. There are few, if any, direct service tertiary care programs within IHS, hence the need for the contract program. Contract Health Services is not an entitlement program; therefore, all alternative resources must be reviewed and used before IHS will contract for a service.

a. On Reservation

(1) Direct Service. To be eligible for any IHS services, including direct services, constituents must produce a Certificate of Indian Blood. Currently the tribes determine the blood quantum for IHS eligibility. IHS has initiated legislation which is pending requiring a blood quantum of 25 percent for IHS eligibility. IHS officials in the Albuquerque Area have estimated that 40 percent of the patients now receiving IHS services would be rendered ineligible if the legislation were enacted. Most IHS direct services are provided by facilities located on or near tribal reservations. IHS hospitals and clinics appear to be overwhelmed with workload, most of which is related to maternal health and child care. An example of workload demands was reported in 1985 by the Navajo Area IHS office located in Window Rock. In providing services to a total Navajo reservation population of under 200,000 there were approximately 180,000 outpatient visits.

(2) Contract Health Services. This program addresses health care needs that cannot be met by IHS medical facilities. To be eligible, a patient must be living in a contract health service delivery area which is defined in regulations as a reservation or county or counties bounded by a reservation. As mentioned earlier, this is not an entitlement program, thus all other resources must be exhausted before authorization is given for contract services. It should be noted that historically IHS has not included veteran status questions on application or registration forms, which accounts for the underutilization of VA programs by IHS.

b. Off Reservation

Approximately 50 percent of the 1.7 million Native Americans in the U.S. live off the reservation in central cities, urban areas outside central cities, and non-metropolitan areas. The 10 urban areas with the largest Indian population are:

* Los Angeles-Long Beach
* Tulsa
* Oklahoma City
* Phoenix

* Albuquerque
* San Francisco-Oakland
* Riverside-San Bernadino-Ontario
* Seattle-Everett
* Minneapolis-St. Paul
* Tucson

(1) Direct Service. Off reservation Native Americans are potentially eligible for direct IHS services if IHS services are available. A cursory review of the above list of cities with the largest Indian populations indicate that most of these cities do not have an IHS hospital: Los Angeles, San Francisco, Riverside, Seattle, Minneapolis, Tucson. Presumably, the Indian patient in need of health care services in most of these cities is without IHS medical service.

(2) Contract Health Services. Off reservation Indians living in areas not bounded by tribal reservations are ineligible for IHS contract health services.

(3) Urban Indian Health Programs. In an effort to partially address the needs of the urban Indian, IHS, along with other community funding agencies, has supported approximately 35 Urban Indian Health Centers throughout the country. These centers are underfunded, but attempt to provide homemaker services, various preventative medical programs, and serve as a place where newly-arrived Indians in the city can feel at home. Insofar as serious medical problems are concerned, the Urban Indian Health Centers are expected to facilitate referrals to appropriate health care institutions.

The Native American living in urban areas not contiguous to reservation land is essentially without IHS services. Regarding other alternatives to IHS care, such as private health insurance, Medicare, and Medicaid, it must be remembered that this is an impoverished population which for the most part is without alternatives. Frequently, Indians working for the tribe on reservations do not contribute to Social Security, therefore, have no retirement or Medicare coverage. Tribal positions frequently turn over following tribal elections, and those that leave the reservation in search of jobs are vulnerable when medical problems occur. Native Americans are eligible for state services when available. However, Medicare is of little use for those under age 65, and Medicaid's income eligibility in New Mexico is $347 per month for outpatient care. Full-time employment in a minimum wage job would render an applicant ineligible for Medicaid outpatient services.

V. THE ROLE OF THE VA IN MEETING THE NEEDS OF INDIAN VETERANS

a. Health Services. IHS provides primary and secondary care through hospitals and clinics which are usually located on or near Indian reservations. Indian veterans living in rural areas that have ready access to these facilities may have their primary and secondary care needs met with considerable convenience as compared to traveling great distances to VA medical centers. The cost savings to the VA must be considerable. However, exclusive use of IHS facilities by Indian veterans, particularly in remote areas, may result in a lack of awareness of an array of veterans benefits and health services that could substantially improve the socioeconomic and health status of the veteran.

There are a number of DM&S programs and services such as VIST (Visual Impairment Services Team), SCI (Spinal Cord Injury), Agent Orange, Ex-POW, Prosthetics, and CNHC (Community Nursing Home Care), which can provide services and equipment not found elsewhere. Frequently neither the veteran nor the IHS physician are aware of these programs; hence, they go unused at great loss to the Indian veteran. There is a serious need for DVB officials through their Veterans Assistance Division and DM&S through their Social Work Service to provide information to Indian veterans and IHS officials regarding what VA benefits and health services are available. The lack of awareness VA staff have of IHS services is matched only by the lack of awareness IHS has of VA benefits and health services. This lack of awareness has undoubtedly cost the IHS considerable sums of money as VA tertiary services are ignored or overlooked when IHS contracts for these services. Since IHS has never included questions on veteran status in their application or registration forms it is assumed that the attending IHS physician may have no awareness that the patient is a veteran and, therefore, may be entitled to VA tertiary care services at no cost to the veteran or IHS. To correct for this oversight, IHS needs to include questions pertaining to veteran status on their registration forms and in addition clearly mark patient charts "VETERAN".

b. Veterans Benefits. In addition to developing innovative methods of providing information to Indian veterans on such benefits as compensation and pension, education, vocational rehabilitation and burial expenses there are additional needs. Perhaps the greatest need is related to the difficulty qualified Indian veterans have in obtaining home loan benefits on reservation or trust lands. This program has benefited tens of thousands of American veterans but has been denied to the qualified Indian veteran residing on reservation or trust lands. Among other actions required is the need for a clearly stated policy to lenders stating sanctions for not successfully processing qualified Indian veterans' applications. Serious effort will be required to resolve this impasse and consideration for the reimplementation of direct home loans by the VA may be necessary. Other actions that could improve the economic status of Indian veterans relate to veterans' employment and training; the involvement of the Small Business Administration in developing a special program to certify Indian veterans; awareness of the Targeted Tax Credit Program; and familiarity with contractual agreement for service opportunities within the Federal system.

VI. FEDERAL HOSPITAL SYSTEMS SHARING ACT - PUBLIC LAW 97-142

The relationship of the Federal Government to Native American tribes has a long and enormously complex history. It is far beyond the scope of this paper to address in detail the nature of this relationship. Suffice it to say the Federal Government has a responsibility that dates back to the early 19th century; however, it is unclear as to what the Federal Government's responsibility is in addressing the health status of Native Americans. The following statement taken from an IHS brochure on Indian health care captures the uncertainty of the Federal responsibility: "While Congress has consistently provided funds for Indian service programs, the courts so far have ruled these benefits are voluntarily provided by Congress and not mandated under the Federal Government's trust responsibility for Indian Tribes." Depending on whom one talks to, the provision of health

care by the Indian Health Service to Native Americans is a "right" or a "privilege". Whatever the government policy is on health care to Native Americans, Indian Health Service plays the instrumental role in carrying out that policy. Whatever the responsibilities of the Federal Government are toward enhancing the health status of Native Americans, be they legal, moral, or historical, it would seem reasonable to include other Federal agencies in fulfilling the federal obligation.

It has been said that the Department of Medicine and Surgery in the VA represents the nation's largest health care delivery system under a single administration. The 172 medical centers and 200+ outpatient clinics that are administered by DM&S (Department of Medicine and Surgery) are distributed widely throughout the country including both urban and rural locations. Many, if not most, of these facilities have affiliations with medical schools which is testimony to the quality of services being delivered. The question raised is how this immense Federal health care delivery system can assist in fulfilling the government's obligations to Native Americans and to do so without jeopardizing service to veterans.

The AVAMC and Kirtland Air Force Base have entered into an agreement whereby the Air Force will utilize both bed space and VA treatment programs for active military personnel and their dependents and retirees and their dependents. The precedent setting endeavor was authorized under the Federal Hospital Systems Sharing Act of 1982. The inclusion of Indian Health Service in existing VA-DOD sharing agreements would appear to have merit in terms of maximizing utilization of Federal facilities, avoiding duplication of services, reducing costs, and providing more appropriate service to Indian constituents. Since a substantial proportion of IHS workload results from maternal and child care activities and since most VA medical facilities do not currently provide pediatric service nor have adequate accommodations for large numbers of female patients, the role of the VA is more suitable for the adult male Native American.

a. Contract Health Services. IHS medical facilities should be required to refer Native American veterans to the closest appropriate VA medical center when tertiary care services are needed. This requirement would be without cost to the veteran or Indian Health Service except possibly for transportation costs. Referral of the non-veteran Native American on a contract basis to VA medical centers on a space available basis could reduce IHS contract costs substantially and maximize utilization of VA beds and programs. Albuquerque Area IHS reports that the actual average per diem rate paid to community hospitals is $1,301. The annual interagency rates established by the Office of Management and Budget for VA-DOD is $347 per day. Depending on volume, substantial savings could be accrued to the Indian Health Service if the agency were included in the VA-DOD sharing agreement.

b. Direct Services. Over half of the Native American population in the U.S. lives off reservation, mainly in urban areas. As mentioned earlier, IHS will provide direct services to urban constituents if IHS facilities are available. Most of the 10 urban areas with the largest Indian populations are without IHS hospitals or IHS operated health centers. There are, however, VA medical centers in all areas listed, with the exception of Tulsa,

which have the potential of providing direct services to Indian constituents assuming there was a sharing agreement. Urban Indian health programs exist in most of the cities but as stated earlier, they function primarily in areas of prevention and referral. It is possible that Urban Indian Health Centers could serve as major referral sources to VA medical centers thus providing Indian constituents with no cost or low cost health care while simultaneously assisting IHS in fulfilling the mission of the agency. Rural VA medical centers in the country might be considered for primary or secondary care or as triage centers for VA tertiary care referral when appropriate IHS facilities are not available. Examples of VA medical centers serving as primary or secondary care resources are St. Cloud, Minnesota; Fargo, North Dakota; Sioux Falls, Fort Meade, and Hot Springs in South Dakota; Fort Harrison and Miles City in Montana; Boise, Idaho; Spokane and Walla Walla in Washington, and numerous other VA facilities in almost any state where IHS has a need. Should the VA and IHS wish to collaborate in the manner described above, it would be necessary for all VA personnel having frequent contact with Native American patients to receive orientation/training to the culture and customs of the local tribes. Many Native Americans feel they or their culture would not be understood nor accepted, hence attitude presents another barrier to accessing VA health care.

In summary, the needs of the urban and rural Native American might be better served, Federal costs reduced, and VA resource utilization maximized if the Indian Health Service were included in the VA-DOD sharing agreement. The contents of a sharing agreement might address: the sharing of patient medical information and other population data; the use of VA tertiary care services including diagnostic procedures offered by medical specialties; use of VA primary and secondary care services when IHS services are not available; transportation; facility transfers; involuntary commitments, and shared educational opportunities.

VII. AVAMC INDIAN VETERAN OUTREACH EFFORTS

Initial efforts to identify and address the needs of Indian veterans were tasked to Social Work Service which serves as the major link between the medical center and the community. Knowledge of VA benefits and health services, knowledge of community agencies and resources, familiarity with community coordinating mechanisms, acceptance of a patient advocacy role, skill to participate in a variety of community development and organization activities, and understanding and sensitivity to cultural variances were essential components of planned efforts to outreach Indian veterans. Of vital importance was the awareness that our focus must provide a match between the paramount needs of the population and the capability of the medical center to meet the need.

a. Gallup Outreach Program. The high incidence of alcoholism among Indians is well known and accepted. A review of existing data indicated that McKinley County, New Mexico, which borders the eastern side of the Navajo Nation, was the number one county among the 3,103 counties in the continental United States in alcohol-related deaths. In 1983, Gallup, a city of 18,000 people in McKinley County, and the major eastern border town of the Navajo Nation, had over 39,000 protective custody cases for drunkenness. The

average was 107 cases per day. It has been said that this number approximates the PCI cases for a city the size of Chicago. It was obvious that alcoholism presented a major health problem. The medical center has a 25 bed alcohol rehabilitation unit which was underutilized by Indian veterans. In January 1986, a social worker from the Alcohol Rehabilitation Unit and a patient services clerk were reassigned to Gallup to serve as a conduit between the Gallup area and our Alcohol Rehabilitation Unit. The social worker, part Sioux-Cree, had considerable experience working with Indians suffering from alcohol problems. The patient services clerk is a Vietnam veteran from the Laguna tribe. Since the program opened in January of 1986, the social worker has averaged 68 visits per month, telephone calls excluded, and has travelled some 10,000 miles. During this period of time the referrals of Indian veterans to our alcohol program has steadily increased. Approximately 15 percent of the patients treated in the alcohol program were Indian, 78 percent of them Navajo. We have recently added a social work assistant to this program and expect the visit count to increase. In addition, we are planning to establish an itinerant schedule to visit the Pueblos of Zuni and Ramah on a regular basis and hope to have a veterans benefit counselor available for the trip.

b. Indian Advisory Committee. The Indian veteran has dual eligibility with the VA and IHS. The Albuquerque Area Indian Health Service operates hospital facilities at Santa Fe, Albuquerque, Acoma-Canoncito-Laguna, and Zuni and also operates several clinics. The Navajo Area Indian Health Service headquartered at Window Rock, Arizona, operates hospitals at Gallup, Fort Defiance, Crownpoint, Shiprock, Chinle, Tuba City and operates clinics at Kayenta, Delcon, and Winslow. IHS facilities are extremely busy, especially the Navajo facilities. It was obvious to medical center staff that historically the Indian veteran has been served mostly by the Indian Health Service, if served at all.

The Indian Health Service has the greatest understanding of Indian health needs and with the Bureau of Indian Affairs the greatest understanding of tribal organization, customs, and values. To understand the need and facilitate planning requires the involvement and cooperation of the Indian Health Service and Bureau of Indian Affairs. In February of 1986 a local Indian Advisory Committee was established and included representatives from IHS, BIA, All Indian Pueblo Council, VA Regional Office, District Counsel, Urban Indian Health Center, and various VA medical center staff. The Committee has served as an extremely valuable mechanism for communication, coordination, and collaboration. The intent is to focus on the needs of each tribe, inviting tribal representatives to Committee meetings to assist in identifying need and to participate in collaborative efforts to meet need. The Committee meets biweekly and probably is the first, if not the only committee of its kind in the country. It predated the national VA Advisory Committee on Native American Veterans by many months. Several members of our local Committee, as well as our Medical Center Director, are members of the national Committee. In addition to serving an instrumental role in developing agendas for the national Committee and preparing the first report to the administrator, the Albuquerque Medical Center hosted the second meeting of the Committee, primarily as a result of interest generated among Committee members to observe the Albuquerque experience in outreaching to Native American veterans.

As elementary as it might appear, the establishment of the AVAMC Indian Advisory Committee has generated numerous plaudits throughout the state for providing for the first time an ongoing interagency planning mechanism. In addition, the VA is currently perceived among the Indian population as providing leadership in attempting to resolve problems through interagency collaboration. The commitment of our Medical Center Director to meeting the needs of Indian veterans, his willingness to travel to the most remote parts of the state and Navajo Nation to meet with tribal leaders, veterans' groups, IHS and BIA officials has solidified acceptance of the VA's sincerity to outreach Indian veterans and to work collaboratively with the tribes and other Federal and state agencies.

c. VA-IHS Veterans Outreach Program. This program was established in 1976 as a result of an interagency agreement between the Veterans Administration and Health Education and Welfare. It was formerly called the VA Outreach Representative Program. In response to Navajo demands for improved VA services to the Navajo Nation, VA Central Office negotiated an agreement whereby the VA would fund 8.00 FTE positions and the IHS would provide office space, telephone support, and GSA transportation at eight Indian Health facilities on the Nation: Gallup, Crownpoint, Shiprock, Fort Defiance, Chinle, Tuba City, Window Rock, and Kayenta. The major functions of these positions as identified in the interagency agreement were the identification of health needs, facilitating access to VA medical facilities, and to provide veterans benefits counseling and assistance. The positions were classified GS-4/7 with the field supervisor position at GS-8. Organizationally the program was assigned to Medical Administration Service, VAMC, Prescott. The Deputy Chief Social Worker, Navajo Area Indian Health Service served as IHS program consultant. The field supervisor is officed at Navajo IHS Area office at Window Rock, AZ, in office space contiguous to the IHS program consultant . The program was transferred to AVAMC October 1, 1986, and organizationally assigned to Social Work Service.

The Navajo Nation is the largest Indian tribe in the U.S. in terms of population and square miles. Recent estimates of the Navajo population is 181,000 people and the reservation covers 25,000 square miles. There is rural and there is "Big Navajo" which is the essence of remoteness. Unlike their pueblo brothers who live in close proximity to neighbors, the Navajo live in single dwellings spaced miles apart from other people. Many of the dwellings seemingly are without water or electricity, and many dwelling sites yield no appearance of livestock or farming activities. It is existence stripped bare of all modern convenience except the automobile. Unemployment on the Navajo reservation has been estimated at 40 to 50 percent. The VA-IHS counselors have focused their attention on informing veteran patients at their respective IHS facilities on what VA benefits are available and how to obtain them. Since being transferred to the AVAMC, the counselors have received orientation and training to the medical center and increasing emphasis is being placed on the counselor assuming an intermediary role between the IHS facility and the VA medical center on health related issues. All of the counselors are Navajo and bilingual.

The program is currently generating an average of 500 visits per month and represents both a significant VA outreach activity as well as a model for interagency collaboration.

VIII. SUMMARY

The AVAMC primary service area is extensive, tri-cultural, and essentially rural. As measured against most national socioeconomic and health status indices, the area compares unfavorably, and this is particularly true for the Indians in the area. There are numerous barriers that prevent the Indian veteran from accessing VA benefits and health care, the most significant being distance, culture, and lack of transportation. Indian Health Service provides most of the direct service medical care to Indian veterans and typically contracts out tertiary care services for Indian veterans rather than refer to VAMC's. Urban Indians are eligible for direct IHS service only when an IHS facility is available and they are not eligible for contract health services. Most major cities are without IHS medical facilities and given the marginal economic status of the Indian population, this places the population at risk. Inclusion of IHS in the VA-DOD sharing agreement has the potential for avoiding duplication of service, reducing costs, maximizing utilization of VA facilities, providing needed services to the Indian population, and facilitating the Federal trust responsibility for Native Americans. The underutilization of VA benefits and health services by Indian veterans requires innovative outreach efforts by Department of Veterans Benefits and the Department of Medicine and Surgery aimed at both the Indian veteran and the Indian Health Service. The AVAMC has established several activities to improve Indian veteran access to the VA and to improve communication and coordination with tribes, states, and other Federal agencies.

APPENDIX B

VA ADVISORY COMMITTEE ON NATIVE AMERICAN VETERANS

REPORT ON

ACCESSIBILITY TO CARE

TASK FORCE MEMBERS:
Andrew Montano, Chairman
Director
VA Medical Center
Albuquerque, NM

Bruce D. Mobberley
Chief, Social Work Service
VA Medical Center
Albuquerque, NM

Niles C. Cesar
Executive Director
Southeast Alaska
Regional Health
Corporation
Juneau, AK

Arthur Thomas
Director
Division of Tribal
Affairs
Indian Health Service
Rockville, MD

JULY 1987

TABLE OF CONTENTS

Page

I. REMOTENESS AND VA UTILIZATION 1

II. NATIVE AMERICAN VETERAN: VA UTILIZATION 2

III. REASONS FOR UNDERUTILIZATION - VA HEALTH SERVICES 3

a. Geography
b. Availability of Resources
c. Indian Health Services Eligibility
d. Culture

IV. STRATEGIES FOR IMPROVING ACCESS TO VA HEALTH CARE 5

V. INTERAGENCY COORDINATION COUNCILS 5

a. Local Indian Advisory Committees
b. Area Native American Coordinating Councils
c. National Native American Veteran Executive Council

VI. SUMMARY 11

ATTACHMENTS

1. - NATIVE AMERICAN POPULATION
2. - LOCATION OF VA MEDICAL CENTERS AND OUTPATIENT CLINICS
3. - DISTANCE FROM COUNTY POPULATION CENTERS TO VA FACILITIES
4. - MEDICALLY UNDERSERVED AREAS
5. - PRIMARY HEALTH MANPOWER SHORTAGE AREAS
6. - PSYCHIATRIC HEALTH MANPOWER - SHORTAGE AREAS
7. - INDIAN HEALTH SERVICE FACILITIES
8. - INDIAN ADVISORY COMMITTEE - ALBUQUERQUE VA MEDICAL CENTER

26-623 - 90 - 5

ACKNOWLEDGEMENTS

Information on VA utilization by veterans living in rural areas including most of the maps listed in the Appendix was prepared by the Health Services Research and Development Service, Veterans Administration Central Office, in collaboration with Health Services Research & Development Field Program, Salt Lake City, Utah. The information was gathered in response to the Veterans Health Care Act of 1984, PL 98-528, requiring the VA Administrator to examine health care to veterans in remote areas.

I. REMOTENESS AND VA UTILIZATION

The Veterans Health Care Act of 1984, Public Law 98-528, Section 202, required the Veterans Administration to examine the issues of access to health care services for veterans residing in areas remote from VA medical facilities. The findings of the first of this two report study indicates 97.1% of all veterans live within 100 air miles of a VA facility. Approximately 131,096 veterans live in counties that are over 150 miles from VA facilities. Veterans with service-connected disabilities utilize VA care nearly five times as often as those with nonservice-connected disabilities. When examined in 25 mile increments, inpatient utilization rates drop slightly after 25 miles, then do not change substantially until a distance of 175 miles or more at which point they drop considerably. Outpatient utilization rates drop substantially (approximately 1/3) between 25 and 50 miles and subsequently continue to fall off more sharply than the corresponding inpatient rates (50% at a distance of 150 miles). Two other findings which are difficult to reconcile are that the further away veterans live and the further they have to travel to receive care, the less likely they are to use VA care; however, it was also determined that veterans in the more rural primary service areas are higher users of VA health care services. A possible explanation of the latter finding is that there are VA facilities available in rural areas or a more likely explanation is that alternative non-VA health care facilities are not available or not financially accessible, hence the veteran seeks the services of the VA.

Among the concluding recommendations of the first report were several with respect to continued agency involvement in providing health care to veterans living in areas remote from VA health care facilities. It was recommended that the Agency:

a. Reflect the complexity of the concept of remoteness in agency policy and planning. Remoteness relates to factors other than air miles. Topography, condition of the roads, weather, culture, availability and accessibility of non-VA health resources, lack of transportation, and the health and economic status of the veteran need to be considered as barriers to accessing VA health care.

b. Continue to consider innovative approaches to furnishing health care for veterans in remote areas. The importance of cooperative and collaborative agreements with existing remote health care agencies such as Community Health Centers and the Indian Health Service was referenced.

c. Ensure involvement of VAMC Community Services Coordinators in care of veterans in remote areas. All VA medical centers are mandated to have a social worker serve as Community Services Coordinator who should have access to adequate information about the remote areas of the medical center's primary service area.

d. Continue flexible agency policy that places primary responsibility for planning and administration of remote arrangements at medical district and medical center levels. It was referenced that personnel at these levels are in the best position to relate to the diverse circumstances that occur from one remote area to another.

Although the findings indicate the vast majority of veterans have reasonable access to VA health facilities, the study acknowledges that there are a variety of factors other than distance that serve as access barriers to VA health care and that there are veteran population groupings that require attention. It was recommended that the agency continue to develop innovative approaches to the care of veterans living in remote areas and that the planning and administration of such efforts occur at the district and medical center levels.

II. NATIVE AMERICAN VETERAN: VA UTILIZATION

Of the 1.7 million Native Americans in the United States, 159,900 are veterans. Native American veterans comprise 0.6% of all living veterans in civilian life. Fiscal Year 85 Native American veteran utilization rates as developed by the VA Office of Management and Statistics indicate that of the 1,031,299, VA hospital discharges, 4,303 were Native Americans, which represents 0.4% of all discharges. Also, the 1985 VA Annual Patient Census showed that in September 30, 1985, of 53,439 patients in VA hospitals on that day, 185 were Native Americans, which represents 0.3% of the total census. The 0.3% representation is supported by Fiscal Year 85 data from the Albuquerque VAMC which shows that of 6,236 discharges to New Mexico and Arizona counties, 186 or 0.3% were Native Americans. Of note is that of the 186 discharges, 26% were to Bernalillo County, (Albuquerque) which is urban. VA medical centers in the Midwest, West, and Southwest accounted for 85% of all Native American veterans discharged from VA medical centers in Fiscal Year 85. Attachment 1 presents the distribution of Native Americans by counties with populations centers over 100 miles from VA facilities and the figures correspond to a Midwest, West, Southwest distribution. Over 75% of hospitalized Native American veterans during Fiscal Year 85 were residents of just ten states, with the highest percentages found at VA medical centers in South Dakota, Oklahoma, Arizona, Montana, and California.

The primary discharge diagnosis for Native American veterans during Fiscal Year 85 varied from all race figures in terms of frequencies but not diagnostic categories. In rank order:

	Diagnoses
Native American Veteran	All VA Users
1. Alcohol dependence & abuse	1. Heart disease
2. Heart disease	2. Malignant neoplasms
3. Digestive disorders other than: abdominal hernias or cirrhosis	3. Psychosis other than drug & alcohol related
4. Injuries & poison	4. Diseases of the digestive system other than abdominal hernias or cirrhosis of the liver
5. Factors other than diseases/injuries	5. Alcohol dependence & abuse

In summary, Native American veterans significantly underutilize VA medical centers. Of those that use the VA, the vast majority reside in the Midwest, West, and Southwest, and the primary diagnosis in terms of frequency is alcoholism.

III. REASONS FOR UNDERUTILIZING VA HEALTH SERVICES

Underutilization of VA health facilities may result from several factors that serve as barriers to accessing VA health care: distance, lack of transportation, climate, road conditions, topography, economic hardship, culture, and health status. However, a major factor for VA underutilization by Native American veterans that transcends access barriers is the dual eligibility Native American veterans have to VA and IHS services. Although there is no hard data available on the utilization of the Indian Health Service by Native American veterans, it is reasonably assumed that Native American veterans in rural areas with access to Indian Health Service facilities would opt for Indian Health Service rather than travel a considerable distance to VA facilities. Underutilization of VA health facilities undoubtedly relates to all of these variables.

a. Geography

Attachments 1, 2, and 3 graphically portray the percentage distribution of Native Americans by county, the location of VA medical facilities, and the distance from county population centers to the nearest VA facility. Distance from county population centers is expressed in air miles and is limited to the 371 counties in the U.S. with population centers over 100 miles from VA facilities. Distance data does not address such issues as topography, weather, road miles, availability of transportation nor the distinctive remote barriers in Alaska and should be used only to provide a general perspective. Attachment 1 clearly demonstrates the Midwest, West, and Southwest distribution of the Native American population, and for the most part the population distribution correlates with the counties most distant from VA health care facilities as seen in Attachment 3. Although it is estimated that over half of the Native American population in the United States live off reservations, residing in urban or metropolitan areas, considerable numbers of Native Americans, including veterans, live in remote, rural areas.

b. Availability of Resources

Utilization of VA health facilities is also contingent upon the availability of transportation, the financial ability to use same, the age and health status of the veteran, and the availability of non-VA health facilities which the Native American can access. Many rural areas of the country are without air or bus service which results in the need for private automobile usage. VA beneficiary travel policy excludes payment for the first hundred miles, which means the patient must assume this cost himself. In addition there is the issue of having to pay for food and lodging for himself and/or a driver should an overnight stay be required. Native Americans as a group are economically deprived. The 1980 U.S. Census indicated that one-third of all Native Americans are at or below the poverty level, which is twice the national average. For the same period, 40.2% of New Mexico Indians were at or below the poverty level. Unemployment is rampant

among Native Americans, especially on the reservations. U.S. Census data for 1980 shows a 13% unemployment rate, which was twice the national average, and a reservation unemployment rate of 27.8%. Many reservations have unemployment rates upward of 50%. CBS News earlier this month presented a squib on the Rosebud Reservation in South Dakota and indicated a 90% unemployment rate. Native Americans in general do not have the economic means to travel long distances for health care. Attachments 4, 5, and 6 show areas of the country by county which are medically underserved and have primary health and psychiatric health manpower shortages. The shortage areas parallel rural counties containing large percentages of Native Americans primarily in the Midwest, West, and Southwest. The maps for the most part indicate the unavailability of non-VA health resources for the general population. The Native American population, however, is eligible for Indian Health Services and Attachment 7 presents the location of Indian Health Service facilities throughout the country. Indian Health Service facilities are normally located in rural areas on or near reservations, and deliver primary and secondary direct service care.

c. Indian Health Service Eligibility

The underutilization of VA health care facilities by Native American veterans may be explained by their use of Indian Health Service facilities. Of the 1.7 million Native Americans in the U.S., approximately 930,000 are eligible for health services provided by the Indian Health Service. Most Native Americans, including veterans would be eligible for both primary and secondary care at available Indian Health Service facilities. Indian Health Service provides no direct tertiary care services, choosing to contract out these services for eligible patients. Contract Health Service is not an entitlement program, at least as far as tertiary services are concerned: all other resources (private insurance, medicare, medicaid, VA) must be explored before eligibility can be established. In addition, the patient must live on a reservation or in reservation states (e.g. Alaska) to be eligible for contract health care services through Indian Health Service. Native American veterans requiring tertiary care services should be automatically screened for VA eligibility and referral; however, Indian Health Service has not normally captured veteran status data in their registration forms, nor are patient charts clearly marked "veteran" so as to alert Indian Health Service physicians to the possibility of a VA referral in the event there is need for tertiary care. Despite the various Indian Health Service eligibility restrictions, it may be assumed that large numbers, if not the majority of Native American veterans, especially those residing on or near reservations, have their health needs met at Indian Health Service facilities. Those that live off reservation, residing in urban or metropolitan areas, are eligible for direct, primary and secondary care services if an Indian Health Service facility is available. They typically would not be eligible for tertiary care services that require contracting with non-IHS facilities. Attachment 7 displays the location of IHS facilities in the U.S. and shows that there are few IHS direct care facilities located in urban areas. For example, California, which contains the largest Native American population in the country, does not have any IHS operated hospitals or clinics, nor does the Los Angeles-Long Beach area, which contains the largest urban Native American population in the country. Whereas it may be assumed that Native American veterans living on or near reservations utilize IHS facilities, there

are serious questions regarding where the urban Native American veteran seeks care.

d. Culture

In addition to geography, unavailability of resources and IHS eligibility, another reason to be considered for the underutilization of VA health service is culture. Culture provides an understanding of the world and through its value reasons for what we do. Shared understanding enhances communication. Native American culture(s) frequently differ from the dominant culture in terms of language, understanding, and expectations. Attitudes toward illness and disease may vary widely and affect a person's decision to seek care and/or accept the care offered. Many Native Americans place great value on indigenous healing systems, sometimes referred to as traditional healing, and seek a blending of traditional and western medicine systems. VA providers and Medical Center Directors need to be cognizant of, and sensitive to cultural differences that impact utilization of VA services.

IV. STRATEGIES FOR IMPROVING ACCESS TO VA HEALTH CARE

The Native American population is distributed primarily throughout the Midwest, West, and Southwestern regions of the U.S. The distribution is almost equally divided between reservations and urban areas within these regions. Geography, unavailability of resources, culture, and utilization of IHS facilities impact the Native American veteran utilization rate of VA health facilities. Planning to reduce access barriers and improve VA utilization must include: the need for greater VA outreach activity in terms of service delivery and dissemination of information, maximizing the referral of Native American veterans from IHS to VA tertiary care facilities; orientation/training of direct service VA personnel or medical records staff to the customs and values of local tribes; and above all, collaboration with IHS, tribes, and other relevant Federal and state agencies for the purpose of identifying and meeting the health needs of Native American veterans. In addition to providing direct health care services to eligible Native American veterans, the IHS has considerably more experience in managing and treating the health care needs of Native American veterans than the VA. Problems associated with distance, lack of transportation, and culture are familiar to IHS providers and they can serve as important resource people to the VA as can tribal representatives. To ensure that Native American veterans appropriately utilize both VA and IHS facilities collaborative efforts are required of both agencies, as well as other relevant community agencies. Established mechanisms aimed at regular and systematic coordination of relevant Federal, state, and tribal organizations for the purpose of policy and procedure development is essential to successful collaboration.

V. INTERAGENCY COORDINATING COMMITTEES/COUNCILS

During the last 18 months, the Albuquerque VA Medical Center has operated a local Indian Advisory Committee for the purpose of identifying program needs, developing an understanding of the organization, policy, and procedures of relevant Federal, state, and tribal programs, developing cooperative relationship with the Indian Health Service and Bureau of Indian Affairs and recommending to the Medical Center Director methods of

improving services to Native American veterans. As seen in Attachment 8, the Committee composition reflects interagency representation. The Albuquerque Indian Advisory Committee has served as an extremely valuable mechanism for interagency communication/coordination and collaboration on an operational level. A need that has surfaced during the Committee's tenure is for the establishment of a higher level coordinating council to act on issues relating to policy in the area. Examples include the sharing of medical, population, and patient identification information; including veterans status question on IHS & BIA registration forms; negotiating the sharing of resources including office space, personnel and GSA vehicles; establishing interagency agreements with IHS for the VA to provide service to non-veteran Native Americans; mandating the referral of Native American veterans to VA tertiary care facilities; and developing area-wide policies on the transportation of Indian veterans to VA facilities. Many, if not all of these sample issues require decision-making authority beyond that of IHS operational staff or Service Unit Directors and some beyond the level of the IHS Area Director. Similarly, VA operational staff do not have the delegated authority to act on all Committee recommendations and depending on the issue, neither does the VA Medical Center Director.

It must be noted that American Indians and Alaska Natives have a unique relationship with the United States Government resulting from treaties and Executive Orders. President Reagan's Indian Policy statement of 1984 restated the "government to government" relationship between the Federal Government and Indian tribes and may serve as a basis for the need of several Federal agencies to give special attention to the Native American veteran population. A three-tiered series of interconnecting coordinating councils at the local, area, and National levels is proposed to facilitate timely decision-making, interagency collaboration, and the fulfillment of the Federal trust responsibility toward Native Americans.

COORDINATING COMMITTEES/COUNCILS
FOR
NATIVE AMERICAN VETERANS

LOCAL	AREA	NATIONAL
Indian Advisory Committee	Native American Veterans Coordinating Council	Native American Veterans Executive Council

Suggested Functions

-Interagency exchange of information	-Act on recommendations from local Indian Advisory Committees	-Establish policy for interagency collaboration
-Identify salient needs of local Native American veterans	-Provide directives for implementation of recommended change	-Develop legislative initiatives as needed

Suggested Functions (Continued)

LOCAL	AREA	NATIONAL
-Identify alternative methods of delivering service	-Establish policy/ procedures on activities related to interagency collaboration	-Facilitate actions requiring highest level authority
-Identify activities requiring Sharing Agreements or Memos of Understanding	-Develop area Sharing Agreements as appropriate	-Implement recommendations of VA Advisory Committee on Native American Veterans
-Develop policies/procedures for referral	-Relate to respective agency decision-makers at headquarters level	
-Initiate all agreed upon actions within limits of authority		
-Implement directions from Area & National Coordinating Councils		

Suggested Committee Composition

-VAMC Staff	-VAMC Directors	-VA Regional Directors: Midwest West, Southwest Regions
-VARO Staff	-VARO Directors	-VA Chief Medical Director/Designee
-IHS Staff	-IHS Area Director	-VA Chief Benefits Director/ Designee
-BIA Representative	-BIA Area Director	-IHS Director/Designee
-Tribal Representation Local Indian Health Board	-Tribal Representation: Area Indian Health Boards	-BIA Director/Designee
-Urban Indian Health Center Representative	-State Director of Offices of Indian Affairs	-Dept of Labor, Office of Veterans Employment Director

Suggested Committee Composition (Continued)

LOCAL	AREA	NATIONAL
-State Office of Indian Affairs		-Dept of Housing & Urban Development
-California/Alaska: Major Community Contract Providers	-California/Alaska: Major Community Contract Providers	Office of Indian Housing Director
		-National Congress of American Indians Director
		-National Indian Health Board Chairman

a. Local Indian Advisory Committees

The need for VA medical centers to establish local committees to address the needs of the Indian veteran is contingent upon the number of Indian veterans in the facility's primary service area. Given the distribution of Native Americans throughout the country it would appear that many VA facilities in the Midwest, West, and Southwest would have reason to review the need to establish a local Indian Advisory Committee. If there is insufficient information to make a determination, consideration should be given to having the facility's Community Services Coordinator acquire whatever information is needed for a decision. VA medical center staff that should be considered for the Committee include: Chief, Social Work Service, an Ambulatory Care physician and other staff that have experience or duties relevant to Indian affairs. The Chief's Assistance Division, VA regional office should be represented on the committee if there is a VA regional office in geographic proximity. Also, a member of the District Counsel's Office, if feasible. Representatives from the Indian Health Service are essential to the success of the committee and should include the Contract Health Officer and Chief Social Worker as a minimum. A representative from the Bureau of Indian Affairs and from the Urban Indian Health Center, if there is one, should also be included. Of equal importance is tribal representation. Depending on the number of tribes in the area, the Committee may seek a representative from each tribe or a representative for all the tribes. In New Mexico there are 19 Pueblo tribes, most of which are represented by the All Indian Pueblo Council, which is comprised of all tribal Governors. This Council appointed a representative to the local VA Indian Advisory Committee. A representative from the local Indian Health Board may also be considered. Agendas and focus will undoubtedly vary with area needs; however, there will probably be a need to exchange information on organizational structures, mission, policy and procedures, programs of each agency/tribe, population/demographic data on Indian veterans, identification of potentially helpful programs, appropriate referral procedures, activities that lend themselves to collaboration in the sharing of resources, and so on. Issues that require higher level authority for resolution would be forwarded to the Area Native American Veterans Coordinating Council.

b. Area Native American Coordinating Councils

The need for Area Coordinating Councils is not as clear as it is for local Medical Center Indian Advisory Committees. In addition, establishment of an Area Coordinating Council presents logistical problems due to distance and expense. Of importance is the need for a mechanism whereby the Area Directors of Indian Health Service and Bureau of Indian Affairs can meet with VAMC and VARO Directors. Local Indian Advisory Committees could raise issues or recommend changes that can only be approved by the respective agency, Directors, or the State Office of Indian Affairs. A Coordinating Council that meets regularly would not only provide a time saving decision-making mechanism but would give visibility to interagency collaboration on behalf of Native American veterans.

The organizational alignments of VA and IHS do not lend themselves readily to clear area demarcations which would include all appropriate agency Directors. The VA divides the country into seven regions and twenty-seven districts. The Indian Health Service has eight areas and three programs. Most of the Indian Health Service areas and programs fall within the Midwest, West, and Southwest regions of the VA. As established earlier, most Native Americans are located in these regions. The Indian Health Service organizational areas appear to be more useful in delineating areas for the establishment of Coordinating Councils. It is essential that IHS and BIA Area Directors be members of a Coordinating Council and VA Medical Centers Directors that have the greatest interest and need. VA regional offices of the Department of Veterans Benefits are more widely distributed, hence there would be greater logistical difficulty in having VARO Directors serve on the Council but effort needs to be made to include them. Again, determining tribal representation could present both logistical and political problems but representation of local and area Indian Health Boards need to be considered. This would need to be tailored to the area. Whenever possible the Director of the State Office of Indian Affairs needs to be included as there appears to be ongoing effort by the Federal Government to shift the "trust responsibility" to the states. Agencies relevant to addressing the needs of Native Americans need to be familiar with current state policies and programs or those that are planned for this population.

AREAS FOR CONSIDERATION AND COUNCIL COMPOSITION

PORTLAND AREA (Northwest Area)	BILLINGS AREA	ABERDEEN AREA (Dakota Area)
IHS Area Dir.-Portland	IHS Area Dir.-Billings	IHS Area Dir.-Aberdeen
BIA Area Dir.-Portland	BIA Area Dir.-Billings	BIA Dir.-Aberdeen
VAMC Dir.-Portland	VAMC Dir.-Miles City -Seattle-Ft.Harrison -Spokane	VAMC Dir.-Ft.Mead -Hot Springs
VARO Dir.-Portland	VARO Dir.-Ft.Harrison -Seattle	VARO Dir.-St. Paul

OKLAHOMA CITY AREA	ALBUQUERQUE AREA	NAVAJO AREA
IHS Area Dir.-OK City	IHS Area Dir.-Albuq.	IHS Area Dir.-Window Rock
BIA Area Dir.-Anadarko	BIA Area Dir.-Albuq.	BIA Area Dir.-Window Rock
VAMC Dir. -OK City	VAMC Dir.-Albuq.	VAMC Dir.-Albuq.
	-Muskogee	VARO Dir.-Albuq.
	-Topeka	-Phoenix
VARO Dir.	-Muskogee	

BEMIDJI PROGRAM	PHOENIX AREA
IHS Prog. Dir.-Bemidji	IHS Area Dir.-Phoenix
BIA Dir.-(to be determined)	BIA Area Dir.-Phoenix
VAMC Dir.-St. Cloud	VAMC Dir.-Phoenix
-Minneapolis VARO Dir.	-Phoenix
-Milwaukee	
	VARO Dir.-St. Paul
-Milwaukee	

TUCSON PROGRAM	CALIFORNIA PROGRAM	ALASKA AREA
IHS Program Dir.-Tucson	IHS Program Dir.	-Sacramento IHS Area Anchorage
BIA Dir.	-Tucson BIA Dir.-(to be determined)	BIA Area Dir.-Juneau
VAMC Dir.-Tucson	VAMC Dir.-Martinez	VARO Dir.-
	-Livermore	Anchorage
	-San Francisco	
	-L.A.Opt.Clinic	
	-Wadsworth	
	-Sepulveda	
	-Loma Linda	
	-San Diego	
VARO Dir.	-Phoenix	VARO Dir.-San Francisco
	-Los Angeles	
	Major Contract Providers	Major Contract Providers

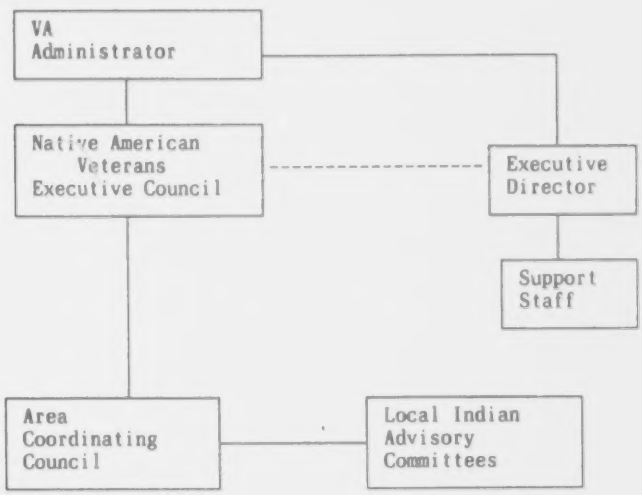
The Indian Health Service Area Offices may serve as the best loci for determining VA representation. Since there could be numerous VA medical centers located within an IHS area, the VA Regional Director could determine which VA Medical Center Directors should be represented. Tribal representation may be determined by existing inter-tribal councils or by the IHS or VA. It is assumed that Bureau of Indian Affairs Area Offices are generally co-located in the same cities as the IHS Area Offices.

c. National Native American Veterans Executive Council

There are numerous Federal and state agencies that have some responsibility for the welfare of Native Americans. As at the local levels, there is an apparent lack of

coordination among agencies nationally which works to the disadvantage of the Native American population as well as being cost-ineffective. The needs of the Native American encompass health care, employment, and housing and all must be addressed if effective solutions are to be found. The Indian Health Service plays the instrumental role in carrying out Federal responsibility for meeting the health needs of Native Americans. The Bureau of Indian Affairs, among other responsibilities, addresses economic subsistence, education, job development and resource development. The Department of Housing and Urban Development is responsible for reservation housing. The responsibility of states in addressing the need of Native Americans is somewhat ambiguous. The issue apparently revolves around the responsibilities of the state for all state residents versus "taxpaying residents". Reservation residents do not pay taxes. There is variation among states in assuming responsibility. The VA has responsibility for providing an array of benefits and health care services to eligibile veterans including Native American veterans. Orchestrating this constellation of agencies and responsibilities to ensure maximum benefit to the Native American veteran is the challenge. A multi-agency council vested with authority to develop policy on interagency collaboration, implement recommended actions from the field, and initiate legislative actions would magnify the needs of the Native American veteran and provide a coordinated and comprehensive approach to problem resolution. Also, well thought out directives based on field recommendations could serve as a significant time saver in implementing needed change. A Special Assistant position with adequate staff would need to be developed in order to provide administrative support to the National Council.

Suggested Table of Organization:



VI. SUMMARY

Native American veterans significantly underutilize VA health care services. Probable causes of the underutilization relate to distance from VA facilities, topography, road

conditions, weather; unavailability of resources including lack of available transportation or inability to defray transportation costs; cultural attitudes toward illness and western medicine; and Native American veteran eligibility for health care through the Indian Health Service. Meeting the needs of Native American veterans requires collaboration among the Veterans Administration, Indian Health Service, Bureau of Indian Affairs, state Offices of Indian Affairs and the tribes. A three-tiered level of interconnecting coordinating councils is proposed to address local, area, and national needs.

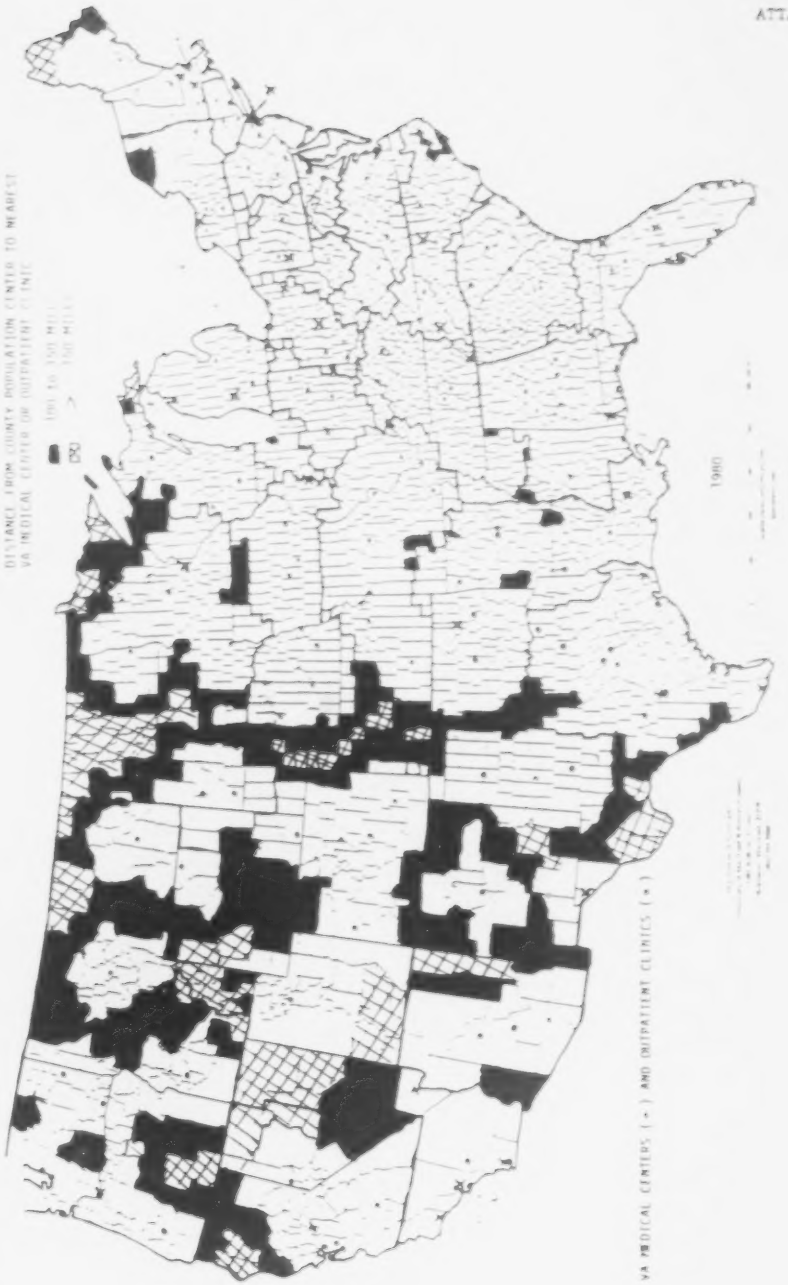
ATTACHMENT 1

Map information is limited to the 371 counties with population centers more than 100 miles from V.A. facilities

ATTACHMENT 2

VA MEDICAL CENTERS (•) AND OUTPATIENT CLINICS (▪)

ATTACHMENT 3


DISTANCE FROM COUNTY POPULATION CENTER TO NEAREST
VA MEDICAL CENTER OR OUTPATIENT CLINIC
1900
VA MEDICAL CENTERS (•) AND OUTPATIENT CLINICS (•)

ATTACHMENT 4

Map information is
limited to the 371
counties with population
centers more than 100 miles
from V.A. facilities.
MEDICALLY UNDERSERVED AREAS (■ - ALL ▲ - PART)

PRIMARY HEALTH MANPOWER SHORTAGE AREAS (1 = MOST SEVERE, 4 = LEAST SEVERE)

Map information is limited to the 371 counties with population centers more than 100 miles from V.A. facilities

ATTACHMENT 5

ATTACHMENT 6

PSYCHIATRIC HEALTH MANPOWER SHORTAGE AREAS (1 = MOST SEVERE, 4 = LEAST SEVERE)

Map information is limited to the 371 counties with population centers more than 100 miles from V.A. facilities

ATTACHMENT 7

MAJOR HEALTH FACILITIES FOR INDIAN & ALASKA NATIVES

VA MEDICAL CENTER
Albuquerque, New Mexico

ATTACHMENT 8
MEMORANDUM 9-45
DEC 16, 1986
122/MDM

INDIAN ADVISORY COMMITTEE

1. Purpose: To establish an Advisory Committee to the Medical Center Director which will identify needs, analyze issues and recommend methods of delivering services to Indian veterans in our PSA.

2. Policy: It is the policy of the Medical Center to provide optimal treatment to our veteran population within resources available. Recognizing that the needs of Indian veterans may differ as a result of culture and location, the Indian Advisory Committee will ensure that the needs of Indian veterans are recognized and appropriately addressed. As the needs of each tribe are addressed, effort will be made to include representatives from the tribe in advisory committee discussions.

3. Responsibilities:

a. To develop mechanisms for determining the salient health care needs of Indian veterans;

b. To develop an understanding of the organizational structures and programs offered by the Navajo Nation, the Mescalero and Jicarilla Apaches, and the 19 pueblos;

c. To develop cooperative relationships with Indian Health Service and other federal and state agencies on behalf of Indian veterans;

d. To recomend to the Medical Center Director methods of enhancing services to Indian veterans.

4. Committee Composition:

a. Albuquerque Area Director, Indian Health Service/Designee

b. Chairman, All Indian Pueblo Council/Designee

c. Tony Secatero, National Service Officer, AmVets

d. Bruce D. Mobberley, ACSW, Chief, Social Work Service, AVAMC

e. Joseph Pugliese, MSW, Social Worker, AVAMC - Chairman

f. Kitty Miller, Attorney, District Counsel Office, AVAMC

MEMORANDUM 9-45
SUBJ: Indian Advisory Committee
DEC 16, 1986
2.

g. Donald Stehr, M.D., Physician, Ambulatory Care, AVAMC

h. Chief, Veterans Assistance, VARO/Designee

i. Fernando Martinez, MSW, Indian Veterans Liaison, AVAMC

j. Navajo Area Director, Indian Health Service/Designee

k. I. R. (Bob) Pacheco, MSW, SW Supervisor, Mental Health Section

l. Albuquerque Area Director/Designee, Bureau of Indian Affairs

m. Director, Albuquerque Urban Health and Human Services Inc.

5. References: Circular 10-85-78, dated 5/14/83: Coordination of VA Health Care Services with State and Local Programs; M-27-1, Part I, Change 25, dated 5/10/85, Chapter 12: Outreach Activities.

6. Replacement: None

7. Automatic Rescission Date: November 1989

ANDREW MONTANO
Director

Distribution: "A"

APPENDIX C

TRADITIONAL HEALING

In the past many Indian veterans have been treated at VA Medical Centers, discharged and returned home to the reservation to be treated by a traditional medicine man, and conversely many have chosen not to avail themselves of traditional medicine. Native American healing arts are diverse and complex and it is difficult, if not impossible, to define what exactly constitutes traditional healing, given the large number of tribes and the differences in language and traditional beliefs.

Generally, holistic healing as practiced by the indigenous people of the North American Continent since time immemorial, is a very sacred institution that delicately balances and applies religion, spirituality, and medicines (derived from the natural surroundings) to the treatment and healing process, commonly termed, "Traditional Healing". Because of the diversity and complexity of the Native Healing arts, they are rarely understood or appreciated by either the modern medical profession or the general population. Yet, these practices are both real and valid for the people that believe and participate in the Native Traditional way of life. Western medical professionals may argue that a medical dichotomy exists in the two cultures. However, Native practitioners refer patients to professionals of modern medicine to be treated for injuries, illnesses, and diseases that are outside the scope of traditional healing. The duality of treatment is best described in a statement made by a Native practitioner who stated that, "We, as Indian people, have the best of both worlds, modern medicine and our traditional healing". This is indeed true.

The enactment of the Indian Religious Freedom Act by Congress, (see Attachment) and the financing of training for Navajo medicine men by the National Institute of Mental Health are two examples that lend credence to the existence, if not validity, of "TRADITIONAL HEALING".

Note: It is not the intent of the Committee to validate nor impose "Traditional Healing" into the Veterans Administration medical profession or any other profession. However, a mutual understanding needs to be reached between the Veterans Administration and Native people, if Indian people are to benefit from the treatment ideology of both cultures. To deny a Native American veteran access to treatment by a Native practitioner in a Veterans Administration medical setting is comparable to denying a Catholic the right to receive Holy Sacrament from a Priest.

PUBLIC LAW 95-341 [S.J.Res. 102]; Aug. 11, 1978

AMERICAN INDIAN RELIGIOUS FREEDOM

For Legislative History of Act, see p. 1262

Joint Resolution American Indian Religious Freedom.

Whereas the freedom of religion for all people is an inherent right, fundamental to the democratic structure of the United States and is guaranteed by the First Amendment of the United States Constitution;

Whereas the United States has traditionally rejected the concept of a government denying individuals the right to practice their religion and, as a result, has benefited from a rich variety of religious heritages in this country;

Whereas the religious practices of the American Indian (as well as Native Alaskan and Hawaiian) are an integral part of their culture, tradition and heritage, such practices forming the basis of Indian identity and value systems;

Whereas the traditional American Indian religions, as an integral part of Indian life, are indispensable and irreplaceable;

Whereas the lack of a clear, comprehensive, and consistent Federal policy has often resulted in the abridgment of religious freedom for traditional American Indians;

Whereas such religious infringements result from the lack of knowledge or the insensitive and inflexible enforcement of Federal policies and regulations premised on a variety of laws;

Whereas such laws were designed for such worthwhile purposes as conservation and preservation of natural species and resources but were never intended to relate to Indian religious practices and, therefore, were passed without consideration of their effect on traditional American Indian religions;

Whereas such laws and policies often deny American Indians access to sacred sites required in their religions, including cemeteries;

Whereas such laws at times prohibit the use and possession of sacred objects necessary to the exercise of religious rites and ceremonies;

Whereas traditional American Indian ceremonies have been intruded upon, interfered with, and in a few instances banned; Now, therefore, be it

Resolved by the Senate and House of Representatives of the United States of America in Congress assembled, That henceforth it shall be the policy of the United States to protect and preserve for American Indians their inherent right of freedom to believe, express, and exercise the traditional religions of the American Indian, Eskimo, Aleut, and Native Hawaiians, including but not limited to access to sites, use and possession of sacred objects, and the freedom to worship through ceremonials and traditional rites.

American Indian Religious Freedom.
42 USC 1996.

42 USC 1996 note.

SEC. 2. The President shall direct the various Federal departments, agencies, and other instrumentalities responsible for administering relevant laws to evaluate their policies and procedures in consultation with native traditional religious leaders in order to determine appropriate changes necessary to protect and preserve Native American religious cultural rights and practices. Twelve months after approval of this resolution, the President shall report back to the Congress the results of his evaluation, including any changes which were made in administrative policies and procedures, and any recommendations he may have for legislative action.

Presidential report to Congress.

Approved August 11, 1978.

LEGISLATIVE HISTORY:

HOUSE REPORT No. 95-1308 accompanying H.J. Res. 738 (Comm. on Interior and Insular Affairs).
SENATE REPORT No. 95-709 (Comm. on Indian Affairs).
CONGRESSIONAL RECORD, Vol. 124 (1978):
Apr. 3, considered and passed Senate.
July 18, H.J. Res. 738 considered and passed House, proceedings vacated and S.J. Res. 102, amended, passed in lieu.
July 27, Senate concurred in House amendment.

APPENDIX D

VA LOAN GUARANTY PROGRAM: PROBLEMS ASSOCIATED WITH RESERVATION LAND

Early Spanish, French and British colonists acknowledged aboriginal ownership of the land prior to "discovery" by Europeans. Indians were considered the true owners of the land. European colonists and later the U. S. Government gained title to aboriginal lands through treaties and statutes. During the 1830's the Supreme Court established and defined the fundamental relationship between the tribes and the Federal Government as one that resembles "that of a ward to a guardian". This became known as the Federal "trust responsibility" for Indians and was aimed at protecting Indian rights.

Trust status of Indian lands includes reservations, individual allotments and tribal land. All three categories are trust property and the majority of these lands are held in trust by the Federal Government for the benefit of tribes or individuals. Land held in trust cannot be sold without the consent of the Federal Government and the tribes. Trust lands include allotment trust land which is land held by the U. S. Government in trust for an individual Indian or for two or more Indians holding individual interests in common and tribal trust land which is held in trust for a tribe. The rights of individual tribal members depends on treaties, agreements, and tribal law but usually the individual has no rights to ownership of any specific parcel of tribal property. Individuals may have certain land use rights which includes occupying a particular tract of land plus grazing, fishing, and timber rights.

An issue that is frequently identified as interfering with the opportunities of a qualified Indian veteran seeking a home loan on reservation property is tribal communal ownership. Individual tribal members can never own their particular tract of reservation land nor can the land be sold to non-Indians. Land usage is usually based on agreements or leases. Insofar as the VA and BIA (Bureau of Indian Affairs) are concerned, the issue of tribal ownership does not pose a problem. DVB Circular 26-65-15 dated May 27, 1965, attached Memorandum of Understanding between the Commissioner of Indian Affairs and the Administrator of Veterans Affairs, waived the need for leases to be freely assignable and transferable with respect to applications from Indian veterans for VA guaranteed, insured, and direct loans for which leasehold interests in trust or restricted land are used as security. Other conditions must be met including the length of the unexpired term of the lease, however, assignability of the leasehold interest is not a condition of acceptance. This Memorandum probably had greater applicability during the period the VA offered direct home loans. The need for the VA and BIA to enter into a memo of understanding to waive the need for "freely assignable" leases implies that there is difficulty in reassignment of leasehold interests. If so, this could present a problem for lending institutions.

Following the termination of the VA Direct Home Loan Program the lending institution became the principal component of the VA Guaranty Home Loan Program. Lending institutions are purported to be reluctant to provide loans to qualified Indian veteran applicants for three major reasons:

a. Assignability/transferability of property or leasehold interests-reservation land is communally owned and cannot be deeded to individuals or corporations. Leasehold interests, if assignable, would have little security value to a lending institution. As referenced in 25 Code of Federal Regulations (CFR Ch. 1 (4-1-87 Edition) 162.12) leases, sub-leases, and assignments are reassignable:

> "(d) With the consent of the Secretary, leases of tribal land to individual members of the tribe or to tribal housing authorities may contain provisions permitting the assignment of the lease without further consent or approval where a lending institution or an agency of the United States makes, insures or guarantees a loan to an individual member of the tribe or to a tribal housing authority for the purpose of providing funds for the construction of housing for Indians on leased premises; provided, the leasehold has been pledged as security for the loan and the lender has obtained the leasehold by foreclosure or otherwise. Such leases may with the consent of the Secretary also contain provisions permitting the lessee to assign the lease without further consent or approval."

b. VA Loan Guaranty Program: The lender making home loans is only guaranteed against loss up to 60 percent of the loan with a maximum guarantee of $27,500; however, this is the policy for all veterans. Lending institutions tend to perceive Indian applicants as poor credit risks.

c. Resale: In the event of default by the Indian veteran, the lending institution could encounter difficulty accessing the reservation for repossession purposes and could have difficulty selling the property given the low demand for non-HUD housing on reservations.

DISCUSSION

Any modification of the VA Loan Guaranty Program would need to address the issue of reassignability of property to lending institutions, the percent of the loan that is guaranteed by VA, and the process of repossession and resale in the event of foreclosure. Since the tribes own the land, the issues of property assignability, repossession and resale would need to be negotiated with tribes on an individual tribal basis.

The Department of Justice, Civil Rights Division, Washington, D. C., has indicated two major problem areas for the lending institution: their lack of knowledge about tribal government and the marketability of the property in the event of foreclosure.

a. Tribal Judicial Process: Lending institutions have misconceptions about the tribal judicial process and fear tribes would resist efforts aimed at repossession. Generalizations are made and applied to all tribes to the disadvantage of the veterans, tribe, and the lending institution. It is essential that lending institutions become familiar with tribal judicial processes and specifically determine if the tribe of a particular loan applicant has a code provision that addresses foreclosure which is acceptable to the lending institution. Lending institutions are in need of education on tribal law and process specific to their area of the country and the tribes need to assume primary responsibility for the execution of those educational endeavors. Generalizations about tribes must be avoided. Tribes need to be individualized and their judicial processes reviewed to determine if satisfactory "dispute mechanisms" have been established.

b. Marketability of Property: In entering into a loan arrangement with a qualified Indian veteran applicant the lending institution must determine if leasehold interests offer sufficient loan security and can be resold in the event of foreclosure. The marketability of reservation property is obviously more restricted than off-reservation property; however, the demand for such properties would vary greatly among tribes. Factors such as the size of the tribe, the geographic location of the tribe, the number of commercial enterprises on the reservation, and the number of BIA and IHS (Indian Health Service) employees on or near the reservation would need to be considered as determinants of marketability. How much of a demand is there for a particular piece of property within the reservation milieu? Marketability assessment would need to be specific to the property and tribe in question.

Re-establishment of the VA Direct Home Loan Program would eliminate the need for the lending institution and would simplify the lending process. Policy discussions with BIA and local tribes regarding property assignability, repossession and resale would need to be negotiated. The demand on reservations for non-HUD housing might not be high, therefore, the VA, the individual tribes, and/or the BIA would need to agree on how any losses created by defaulted loans would be absorbed or shared.

Another alternative to the existing VA Loan Guaranty Program would be to have the tribe agree to co-sign the loans from lending institutions or a VA Direct Home Loan Program. This approach would include the tribe initially in the loan application process and serve as evidence that the tribe is willing to assume "ownership" of any problems that might result from a foreclosure. The development of tribal home loan programs by economically solvent tribes would eliminate any obstacles to leasehold assignability, issues related to judicial process and repossession, and the future marketability of the property.

Summary. The underutilization of the VA Loan Guaranty Program by qualified Indian veterans for guaranteed home loans on reservation land appears to be related to the following issues: assumed inability of the Indian applicant to obtain title to land on reservations; assumed difficulty in reassigning title to lending institutions; assumed problems associated with accessing reservations in the event of foreclosure; assumed lack of a market for non-HUD housing on reservations; and possibly the insufficiency of the VA guarantee which is for only 60% of the loan. Efforts to address the problems associated with the VA Loan Guaranty Program would require among other things, collaborative educational activity at local and area levels aimed primarily at the tribes and lending institutions. The tribes need to target specific lending institutions for the purpose of demonstrating the effectiveness of tribal foreclosure mechanisms and to offer information on the marketability of the property in the event of default. Although many of the same issues would remain, the reimplementation of the VA Direct Home Loan Program would eliminate the need to include lending institutions in the educational process and would expedite the correction of the problem.

ATTACHMENT 1

Department of Veterans Benefits
Veterans Administration
Washington, D. C.

DVB Circular 26-65-15

May 27, 1965

MEMORANDUM OF UNDERSTANDING BETWEEN THE COMMISSIONER OF INDIAN AFFAIRS AND THE ADMINISTRATOR OF VETERANS' AFFAIRS

1. The purpose of this circular is to transmit copies of a recently signed Memorandum of Understanding Between the Commissioner of Indian Affairs and the Administrator of Veterans' Affairs. A copy of the agreement is attached as Exhibit A for your reference.

2. A form for leasing tribally owned land has been prepared which meets the approval of the FHA, The Federal National Mortgage Association and the VA for home loan financing. A copy of the lease form is attached as Exhibit B. The provisions of Regulations 4350 and 4515 pertaining to leases being freely assignable and transferable are hereby waived with respect to leasehold estates acquired through the use of the approved form.

3. Loans to Indian Veterans must meet all the requirements of Chapter 37, Title 38, U. S. Code, relating to income, expenses, satisfactory credit risk and reasonable value requirements. It should be noted that the Bureau of Indian Affairs has agreed to give the VA such credit information as it may have concerning the veteran. Loan Guaranty offices receiving inquiries concerning loans on Reservation lands should consult with field offices of the BIA for such assistance as may be necessary.

4. Where individual Indians own land in fee simple, processing of applications for guaranteed, insured and direct loans will continue to be handled in the same manner as any other application. It is the responsibility of the mortgage lender in guaranteed and insured loan cases to ascertain whether the Indian holds his land on a fee basis, in a trust or on a restricted basis.

5. Since leaseholds involving tribal lands are generally outside the jurisdiction of state courts, the majority of legal actions involving such leaseholds must be brought in Federal Courts. When judicial foreclosure of direct loans involving such leaseholds is necessary the cases will be referred to the U. S. Attorney or Department of Justice in accordance with the General Counsel's letter of February 18, 1965 to Chief Attorneys.

6. Attached is a copy of a release (Exhibit C) dealing with the appraisal of leasehold estates approved for use by the Honolulu Regional Office. The methods of arriving at the leased fee value and reasonable value shown in that release are approved for application generally. Examples showing the method of capitalizing the rent income as well as reversionary interest are included in the attached release as well as applicable Inwood Factor Tables. In arriving at the lot value the actual ground rent attributable to the land should be ascertained and used in the computations involved. In cases where the consideration for the lease is $1 for each 25 years, the Reasonable Value should be limited to an amount not to exceed the cost of construction as the upper limit of value.

7. Requests for appraisal involving the creation of leasehold, ground rental arrangements, or lesser estates than fee simple should be submitted to Central Office for prior approval in accordance with Paragraph 2.04c, M4A-8, Part II. Please submit future cases to this office together with pertinent instruments including appraisals and your recommendations.

A. W. STRATTON
Chief Benefits Director

Attachments

Distribution: DVE publications code 2023
FD All other elements same as M4A-8, Part I

DVB CIRCULAR 26-65-15
EXHIBIT A

MEMORANDUM OF UNDERSTANDING BETWEEN THE COMMISSIONER OF INDIAN AFFAIRS AND THE ADMINISTRATOR OF VETERANS' AFFAIRS

SUBJECT: Veterans' Administration Guaranteed, Insured or Direct Loans to Indian Lessees of Trust or Restricted Land

I. Purpose.

This memorandum of understanding sets forth the policies that will be followed by the Bureau of Indian Affairs (BIA)and the Veterans' Administration (VA) with respect to applications from Indians for VA guaranteed, insured or direct loans for which leasehold interests in trust or restricted land are proffered as security.

II. Lease Requirements.

Where leasehold interests in trust or restricted land are offered as security for direct VA loans or for loans to be guaranteed or insured by the VA, leases shall meet the following requirements:

1. Each lease must have an unexpired term of at least 50 years from the date of the execution of the mortgage. The conditions of this requirement will be considered as having been met in those cases where, as a result of Federal restriction on Indian leasehold limits, a lease is executed as of the date of the execution of the mortgage for a term of 25 years with provision for renewal thereof automatically and without notice on the same terms and conditions for an additional term of 25 years.

2. Each lease shall be in a form which has been approved by the Veterans' Administration, the Bureau of Indian Affairs and the Federal National Mortgage Association.

III. BIA Mortgage Approval Commitment and Certificate.

1. Upon approval of the proposed loan transaction the BIA will issue a commitment stating that the mortgage will be approved upon issuance of a commitment by the VA. The BIA commitment will be in the following form:

"Mortgage Approval Commitment

The undersigned agrees, on behalf of the Secretary of the Interior, to approve a mortgage of leasehold interests in trust or restricted land as security for a direct VA loan (or a loan guaranteed or insured by VA) to _____.

_____
(Signature of approving officer)

_____
Title"

2. The following certification to be executed by the authorized representative of the Secretary will be inserted after the jurat at the end of the mortgage:

4.

"Certificate of Approval

Pursuant to the Act of March 29, 1956 (70 Stat. 62, 25 U.S.C. 483a) and authority delegated to the Commissioner of Indian Affairs by the Secretary of the Interior (25 CFR 121.61, 23 FR 6493-6495, August 22, 1958) and to Area Directors by section 132 of Order 551, as amended April 27, 1963 (28 FR 4206), the foregoing mortgage is hereby approved on behalf of the Secretary of the Interior.

_____
Area Director"

(Note: In the event the approving official is other than the Area Director, the authorities above cited should be appropriately changed.)

IV. Credit Information.

Upon request of either the mortgagee or the VA, and with the consent of the Indian applicant, the BIA will furnish information relative to its credit experience, if any, with the Indian applicant. Included in this information will be a statement as to whether the applicant has exclusive control of his own funds or whether any of his funds are subject to control by the BIA. Verification will also be supplied as to the amount

of the applicant's income received through the BIA. Where the applicant's funds are subject to control by the BIA, a complete report on such funds will be supplied, together with a statement as to whether the funds may be released and used by the applicant for payment of the proposed mortgage loan.

V. Servicing VA Guaranteed, Insured or Direct Mortgage Loans.

While the servicing of a VA guaranteed, insured or direct loan is the responsibility of the lender or holder of the mortgage as required by VA regulations, upon request of the VA, the mortgagee or the borrower, the BIA will assist to the extent possible in correcting difficulties that arise in connection with the obligation under the mortgage. This shall not be construed, however, as involving monetary assistance from the BIA. The BIA further agrees to cooperate within its authority in any remedial action that may be necessary or desirable.

APPROVED: John O Crow DATE: MAY 7 - 1965
Commissioner of Indian Affairs

APPROVED: [signature] DATE:
Administrator of Veterans' Affairs

DVB CIRCULAR 26-65-15
EXHIBIT B

Form 5-1495
Aug 1964

UNITED STATES
DEPARTMENT OF THE INTERIOR
Bureau of Indian Affairs

LEASE NO. _____

CONTRACT NO.
_____

RESIDENTIAL LEASE

THIS LEASE, made and entered into between _____

_____, hereinafter designated as "LESSOR", and _____, member(s) of the _____ residing upon the _____ Indian Reservation, _____, hereinafter designated as "LESSEE(S)".

WITNESSETH:

1. SECRETARIAL APPROVAL. As used in this Lease, the term "SECRETARY" means the Secretary of the Interior or his duly authorized representative. This Lease is subject to the approval of the Secretary pursuant to the Act of August 9, 1955, 69 Stat. 539, as amended; 25 U.S.C. 415.

2. PREMISES. Lessor, as authorized by law and in accordance with a resolution adopted by the _____ on _____, hereby leases to the Lessee(s) all that tract or parcel of land situated on the _____ Indian Reservation, County of _____, State of _____, and described as follows:

3. USE OF PREMISES. The object of this Lease is to enable the Lessee(s) to construct, improve and/or maintain a dwelling and related structures on the premises, and otherwise to use or occupy said premises for residential purposes.

4. TERM. Lessee(s) shall have and hold the premises for a term of twenty-five (25) years beginning on the effective date of this Lease. This Lease shall automatically and without notice renew for an additional term of twenty-five (25) years on the same terms and conditions contained herein. This Lease may not be terminated by either or both parties during its initial or renewal term if, and as long as, the Lease and/or any improvements on the premises, or any interest therein, are mortgaged or otherwise pledged as security for any loan in accordance with the provisions hereof, unless consent in writing to such termination is given by the lender and, when FHA insurance or VA guaranty or insurance is in force, by the Federal Housing Administration or the Veterans Administration, as the case may be. This Lease shall not be subject to any forfeiture or reversion and shall not be otherwise terminable, if such event would adversely affect any interest in the premises, including improvements thereon, acquired in accordance with the provisions hereof by the holder of any mortgage or other lien, or of any purchaser at a foreclosure sale under such mortgage (or lien) or under any conveyance given in lieu of foreclosure, or of any holder subsequent to such purchase.

DVB CIRCULAR 26-65-15
EXHIBIT B

5. RENT. The improvement of housing for _____ families is a public purpose of the Lessor. The consideration for this lease is (1) the said purpose, (2) the promise, hereby given, of Lessee(s) to pay the Lessor rent at the rate of One Dollar ($1.00) for each twenty-five (25) year term, payment to be made each term in advance, (3) the extinguishment, hereby agreed to by Lessee(s), of any and all use rights heretofore held by Lessee(s) in the premises, so that Lessee(s) shall hereafter hold rights only by virtue of this lease, and (4) other good and valuable considerations, the receipt of which is hereby acknowledged by Lessor. It is agreed that there shall be no adjustment of the rent if the Lease is terminated before its term otherwise would expire or in the event that any part of the premises is taken by condemnation for highway or other public purposes.

6. IMPROVEMENTS. All buildings or other improvements now existing or hereafter constructed on the premises shall be the leasehold property of the Lessee(s) during the term of this Lease, including any extension or renewal thereof.

7. USE RIGHTS. Upon expiration of this Lease, or upon its termination in accordance with the terms hereof, unless such termination is due to default upon the part of Lessee(s), Lessee(s) or any successors in interest shall be entitled to use rights in the premises if qualified under the laws and customs of the _____. If not so eligible, Lessee(s) and any successors in interest shall, upon demand, surrender to Lessor upon expiration or other termination of this Lease complete and peaceable possession of the premises and all improvements thereon, which shall be the property of the _____.

8. FEDERAL SUPERVISION. (a) Nothing contained in this Lease shall operate to delay or prevent a termination of Federal responsitilities with respect to the premises by the issuance of a fee patent, the lifting of restrictions on alienation, or otherwise during the term of the Lease; such termination, however, shall not serve to abrogate the Lease.

(b) No member of Congress or any delegate thereto or any Resident Commissioner shall be admitted to any share or part of this Lease or to any benefit that may arise herefrom.

(c) The Lessee(s) agree(s) not to use or cause to be used any part of said premises for any unlawful conduct or purpose.

9. QUIET ENJOYMENT. Lessor agrees to defend the title to the premises and also agrees that Lessee(s) and any successors in interest shall peaceably and quietly hold, enjoy and occupy the premises for the duration of this Lease without any hindrance, interruption, ejection or molestation by Lessor or by any other person or persons whomsoever.

10. INHERITANCE. This Lease may be transferred by will or by intestate inheritance in accordance with the laws and customs of the _____

11. ASSIGNMENT. Except as otherwise provided herein, Lessee(s) shall not assign this Lease without the prior written consent of the Lessor and, if this Lease and/or any improvements on the premises are mortgaged or pledged as security for a loan, without the written approval of the lender and, when FHA insurance or VA guarantee or insurance is in force, of the Federal Housing Administration or Veterans Administration, as the case may be. Lessee(s) may assign this Lease or deliver possession of the premises, including any improvements thereon, to the lender, its successors in interest, or the FHA or VA, as the case may be, if Lessee(s) default(s) in any mortgage or other loan agreement for which the Lease and/or improvements on the premises are pledged as security, and, in such event, the lender, its successors in interest, or the FHA or VA, in turn may transfer this Lease or possession of the premises to a successor lessee. Nothing in this Lease shall prevent the Lessee(s) from executing and recording a mortgage, declaration of trust and/or other security instrument as may be necessary to obtain financing for the construction and/or improvement of a dwelling and related structures, or shall prevent the mortgagee or other lender from foreclosing or instituting other appropriate proceedings under law in the event of default of any mortgage or other loan agreement by the Lessee(s). Except in cases involving loans

for home construction or home improvement by a bank or other recognized lending institution or the VA, where no such consent or approval of Lessor shall be required, lessee(s) may not execute a mortgage, declaration of trust or other security instrument pledging their interest in this Lease or any improvements on the premises without the prior consent of Lessor and the approval of the Secretary.

12. OPTION. In the event of default by the Lessee(s) on any mortgage or other loan agreement for which this Lease or any improvements on the premises are pledged as security, Lessor shall have the right of first refusal to acquire the Lessee's interest in the premises (subject to all valid liens and encumbrances) upon (a) payment of all sums then in arrears, and (b) either payment of the balance of the loan or assumption of the mortgage. Said right of first refusal may be exercised at any time within thirty (30) days after notice in writing from the lender of the Lessee's default, which notice shall be given before the lender invokes any other remedies provided under the mortgage or by law, and shall be exercised by notice in writing from the Lessor to the Lessee(s) and the lender; provided, however, that the Lessee(s) shall have fifteen (15) days from the date of the latter notice to cure the default. The estate acquired by the Lessor through exercise of said right of first refusal shall not merge with any other estate or title held by the _____ as long as this Lease and/or any improvements on the premises, or any interest therein, are mortgaged or otherwise pledged as security for any loan, and said estate shall remain subordinate to any valid and subsisting mortgage or other security instrument.

13. EFFECTIVE DATE. This Lease and all its terms and provisions shall be binding upon the heirs, successors, executors, administrators and assigns of the Lessee(s) and any successor in interest to the Lessor, and shall take effect on the _____ day of _____, 19___.

14. OBLIGATIONS TO THE UNITED STATES. It is understood and agreed that while the leased premises are in trust or restricted status, all of the Lessee's obligations under this lease, and the obligation of his sureties, are to the United States as well as to the owner of the land.

_____, LESSOR

ATTEST:

By_____
(Authorized Official)

_____

WITNESS:

_____, LESSEE

_____

_____, LESSEE

APPROVED:

DATE:

_____

_____

Secretary of the Interior

DVB CIRCULAR 26-65-15
EXHIBIT C

VETERANS ADMINISTRATION
REGIONAL OFFICE
P. O. BOX 3303
Honolulu 1, Hawaii

August 19, 1959

LOAN GUARANTY INFORMATION BULLETIN NO. L-294
(This rescinds Bulletin No. L-284, dated Oct. 15, 1958)

SUBJECT: VA Modified Leasehold Processing Procedures

1. This office has been instructed by our Central Office to institute a new method of appraising leasehold cases. Basically, the new method is one that has been recognized in appraisal circles for sometime. With the modified method, the entire stipulated rent income as well as the value of the land at the end of the term of known rent is considered in arriving at the value of the leased fee.

2. Basically, our computations involve the separation of the value of the lessor's interest from the total fee value of the property with the resultant amount representing the lessee's interest. This is accomplished by:

a. Capitalizing the fixed annual rent as an annuity for the number of years in the initial term; to this add, if applicable,

b. The present worth of the capitalized rent for the second term; plus

c. The reversionary value of the land at the end of the term or terms of fixed rent.

(Step b will not apply unless two terms of fixed rent are specified in the lease document.)

3. Attached to this letter are two factor tables which are required for calculating the value of the leased fee.

a. Present Value of Level Annuity at 5-1/4%

b. Present Value of One Deferred at 5-1/4%

4. For explanation purposes, the chart entitled "Present Value of Level Annuity" may be described as a series of periodic payments in which each payment is for an equal amount. As applied to capitalization, a level annuity is a series of yearly net incomes accruing at the end of each year in which the successive yearly installments are for the same amount. The present value of a level annuity is the sum of the present values of all the installments of income of which it is composed.

5. With respect to our chart entitled "Present Value of One Deferred," it may be described as the present worth of an amount which may be defined as a single payment collectible at a definite future date discounted at a stated rate of interest.

DVB CIRCULAR 26-65-15
EXHIBIT C

6. The following is an example of the manner by which we shall now calculate the value of the leased fee:

Considering a lease which has an initial term of fixed rent after which the rent for the remaining term is subject to adjustment by arbitration. The initial rent is capitalized as an annuity (using factor table "Present Value of Level Annuity") for the number of years of the fixed rent. To this figure is added the value of the land reversion, which is the estimated market price of site in fee discounted to present worth. (In the latter use factor table "Present Value of One Deferred.") For example, assume 55-year lease with fixed annual rental of $80 for the first 31 years after which the rent is subject to arbitration for the remaining 24 years. The estimated market price of the site in fee simple is $6,000. Capitalization rate will be 5-1/4%.

Example No. 1

Annual rent	$80
Term	31 years
Fee lot value	$6,000
Fee improved value	$18,500

Computing Present Value of Level Annuity

Annual rent	$80
Term	31 years
Capitalization rate	5-1/4%
Factor (Taken from Table "Present Value of Level Annuity" at 5-1/4% for 31 years)	15.1486

$80 x 15.1486 = (Present value of $80 annual rent for 31 years) $1,210

Computing the Reversionary Value of the Land
(Present Value of One Deferred)

Estimated market price of site	$6,000
Reversion date, at end of	31 years
Capitalization, or discount rate	5-1/4%
Factor (Taken from Table "Present Value of One Deferred" at 5-1/4% for 31 years)	.2047

$6,000 x .2047 = (That amount which invested today at 5-1/4% interest compounded annually will produce $6,000, 31 years hence) $1,230

Therefore, $1,210 + $1,230 = (The value of the leased fee) $2,440

DVB CIRCULAR 26-65-15
EXHIBIT C

To illustrate the procedure for determining the reasonable value:

Fee value of the property	$18,500	
Minus leased fee	$ 2,440	
	$16,050	
Maximum loan and reasonable value		$16,050

Example No. 2

Annual rent	$225	
Term	31 years	
Fee lot value	$9,000	
Fee improved value	$24,000	
Lease rent, per annum	$225	
Term	31 years	
Capitalization rate	5-1/4%	
Factor (P. V. of Level Annuity)	15.1486	
$225 x 15.1486		$ 3,410
Plus:		
Estimated market price of site	$9,000	
Reversion date, at end of	31 years	
Capitalization or discount rate	5-1/4%	
Factor (P. V. of One Deferred)	.2047	
$9,000 x .2047		$ 1,840
Leased fee		$ 5,250
Estimated fee value	$24,000	
Minus leased fee	$ 5,250	
	$18,750	
Maximum loan and reasonable value		$18,750

Example No. 3 - Involves increased rent during the specified term

Lease rent designated for 35 years

First 25 years at $175 per year
Additional 10 years at $225 per year

Fee lot value	$8,250
Fee improved value	$22,000

DVB CIRCULAR 26-65-15
EXHIBIT C

Lease rent, per annum $175
First term . . . . . 25 years
Rate 5-1/4%
Factor (P. V. of Level Annuity) 13.7475

$175 x 13.7475 . . . . . $ 2,405

Plus:

Lease rent, per annum $225
Second term . . . . . 10 years
Rate 5-1/4%
Factor (P. V. of Level Annuity at 5-1/4%
for 35 years 15.8703
Deduct P. V. of Level Annuity
at 5-1/4% for 25 years) . . . 13.7475 = 2.1228

$225 x 2.1228 . . . . . $ 480

Present worth at capitalized rent for total
term of fixed rent . . . . . $ 2,885

Plus value of reversion:
Estimated market price of site . . . $8,250
Reversion date, at end of . . . . . 35 years
Capitalization or discount rate . . . 5-1/4%

$8,250 x factor (P. V. of One Deferred
for 35 years) .1668 . . . . . $ 1,375

Leased fee . . . . . $ 4,260

Estimated fee value $22,000
Less leased fee . . . . . $ 4,260
$17,740

Maximum loan and reasonable value $17,750

GEORGE W. BICKNELL
Manager

Att: 2
Inwood Factor Tables

DISTRIBUTION:
All lenders, builders, sponsors and
other CI loan participants

DVB CIRCULAR 26-65-15
EXHIBIT C

INWOOD FACTOR TABLE

PRESENT VALUE OF ONE DEFERRED AT 5-1/4%

Years	Factor	Years	Factor
1	.9501	21	.3415
2	.9027	22	.3244
3	.8577	23	.3082
4	.8149	24	.2929
5	.7743	25	.2783
6	.7356	26	.2644
7	.6989	27	.2512
8	.6641	28	.2387
9	.6310	29	.2268
10	.5995	30	.2154
11	.5696	31	.2047
12	.5412	32	.1945
13	.5142	33	.1848
14	.4885	34	.1756
15	.4642	35	.1668
16	.4410	36	.1585
17	.4190	37	.1506
18	.3981	38	.1431
19	.3783	39	.1359
20	.3594	40	.1292

DVB CIRCULAR 26-65-15
EXHIBIT C

INWOOD FACTOR TABLE

PRESENT VALUE OF ONE DEFERRED AT 5-1/4%

Years	Factor	Years	Factor
41	.1227	58	.0514
42	.1166	59	.0489
43	.1108	60	.0464
44	.1053	61	.0441
45	.1000	62	.0419
46	.0950	63	.0398
47	.0903	64	.0378
48	.0858	65	.0359
49	.0815	66	.0341
50	.0774	67	.0324
51	.0736	68	.0308
52	.0699	69	.0293
53	.0664	70	.0278
54	.0631	71	.0264
55	.0599	72	.0251
56	.0570	73	.0239
57	.0541	74	.0227

DVB CIRCULAR 26-65-15
EXHIBIT C

INWOOD FACTOR TABLE

PRESENT VALUE OF ONE DEFERRED AT 5-1/4%

Years	Factor	Years	Factor
75	.0215	92	.0090
76	.0205	93	.0086
77	.0194	94	.0081
78	.0185	95	.0077
79	.0176	96	.0074
80	.0167	97	.0070
81	.0158	98	.0066
82	.0151	99	.0063
83	.0143	100	.0060
84	.0136		
85	.0129		
86	.0123		
87	.0117		
88	.0111		
89	.0105		
90	.0100		
91	.0095		

DVB CIRCULAR 26-65-15
EXHIBIT C

INWOOD FACTOR TABLE

PRESENT VALUE OF LEVEL ANNUITIES AT 5-1/4%

Years	Factor	Years	Factor
1	.9501	21	12.5437
2	1.8528	22	12.8681
3	2.7105	23	13.1763
4	3.5255	24	13.4692
5	4.2997	25	13.7475
6	5.0354	26	14.0118
7	5.7343	27	14.2630
8	6.3984	28	14.5017
9	7.0294	29	14.7287
10	7.6288	30	14.9439
11	8.1984	31	15.1486
12	8.7396	32	15.3431
13	9.2538	33	15.5279
14	9.7423	34	15.7034
15	10.2065	35	15.8703
16	10.6475	36	16.0287
17	11.0665	37	16.1793
18	11.4646	38	16.3224
19	11.8428	39	16.4583
20	12.2022	40	16.5875

18.

DVB CIRCULAR 26-65-15
EXHIBIT C

INWOOD FACTOR TABLE

PRESENT VALUE OF LEVEL ANNUITIES AT 5-1/4%

Years	Factor	Years	Factor
41	16.7102	58	18.0682
42	16.8268	59	18.1171
43	16.9376	60	18.1635
44	17.0428	61	18.2076
45	17.1428	62	18.2495
46	17.2378	63	18.2893
47	17.3281	64	18.3271
48	17.4139	65	18.3631
49	17.4954	66	18.3972
50	17.5728	67	18.4297
51	17.6464	68	18.4605
52	17.7163	69	18.4898
53	17.7827	70	18.5176
54	17.8458	71	18.5440
55	17.9057	72	18.5692
56	17.9627	73	18.5930
57	18.0168	74	18.6157

DVB CIRCULAR 26-65-15
EXHIBIT C

INWOOD FACTOR TABLE

PRESENT VALUE OF LEVEL ANNUITIES AT 5-1/4%

Years	Factor	Years	Factor
75	18.6372	92	18.8757
76	18.6577	93	18.8842
77	18.6772	94	18.8924
78	18.6956	95	18.9001
79	18.7132	96	18.9075
80	18.7299	97	18.9145
81	18.7457	98	18.9211
82	18.7608	99	18.9274
83	18.7751	100	18.9334
84	18.7887		
85	18.8016		
86	18.8139		
87	18.8255		
88	18.8366		
89	18.8471		
90	18.8571		
91	18.8666		

APPENDIX E

NETWORKING WITH ALCOHOLISM PROGRAMS

It is well documented that American Indians and Alaska Natives have the highest alcoholism rate among ethnic groups in North America. Proportionately, a large percentage of Native American veterans suffer from the disease of alcoholism. Very few resources are available to tribes and tribal organizations to provide adequate treatment. At best the delivery of health care and treatment for alcoholism and chemical dependency is "piece-meal". With the exception of private facilities, there are few comprehensive care units available to Native Americans for the treatment of alcoholism and chemical dependency. The cost of private care facilities render them economically inaccessible to most Native Americans.

Many Veterans Administration Medical Centers provide comprehensive care units needed to ensure a continuum of care and treatment for alcoholic veterans. Accordingly, it is imperative that Veterans Administration Medical Centers, where appropriate, enter into sharing agreements with the Indian Health Service and tribally-operated Substance Abuse Programs delineating policies and procedures for patient identification, referral, treatment, aftercare, and follow-up of Native American veterans.

Such an agreement is exemplified by the referral model that was recently developed in Albuquerque, New Mexico between the Indian Pueblo Council "Two Worlds" Alcoholism Program and the Albuquerque Veterans Administration Medical Center. The agreement basically provides a process for the screening, staffing, referral, treatment and case management of Native American veterans that are directed by tribal courts to receive treatment. (See Attachment).

DATE: December 18, 1986

FROM: Chairman, Indian Advisory Sub-Committee

SUBJ: Proposed Policy of Referral of Tribally Committed Veterans to VAMC Inpatient Alcohol Program

TO: Indian Advisory Committee

1. Purpose. To establish a referral policy and procedure for Native American veterans who are tribally committed for alcohol treatment to the All Indian Pueblo Council, Two Worlds Program.

2. Policy. VA Medical Center, Albuquerque, will accept appropriate referrals and assessments completed by the All Indian Pueblo Council (AIPC), Two Worlds Project, and schedule for inpatient treatment in the Alcohol Dependency Treatment Program. These are referrals who are under tribal commitment status to the Two Worlds Project and who are determined through assessment by that program to require inpatient course of treatment.

3. Responsibility.

a. The Two Worlds Project will maintain ongoing responsibility for tribal commitment (legal) status and for informing all appropriate authorities about treatment/outcome and reports.

b. VA Medical Center will be responsible for providing timely, quality, and compassionate inpatient treatment as per program (Ward 8) policies and procedures. Veterans will be referred back to their communities via Two Worlds Project.

4. Procedure:

a. Tribal Court. In situations where there is a Native American veteran who needs to be committed for assessment and/or inpatient alcohol treatment, contact will be made with the Two Worlds staff to arrange for an assessment to be made of that veteran. A determination of the appropriateness for inpatient treatment or other treatment recommendations will be made back to the Tribal Court. The veteran will then be court ordered to the All Indian Pueblo Council, Inc., Two Worlds, but may first in many cases be sent to IHS/PHS Hospital for detoxification prior to evaluation.

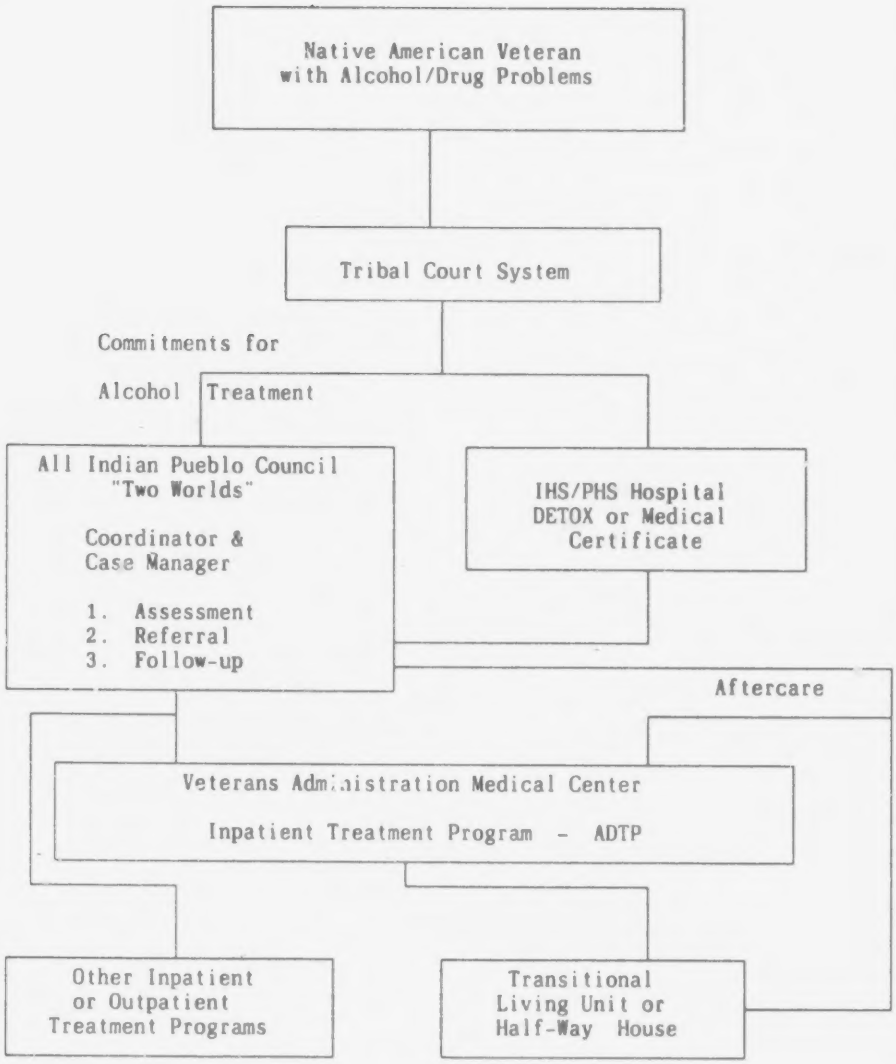
b. Two Worlds. The Two Worlds will receive the Tribal Court committed veteran for a period of evaluation and assessment. Appropriate assessment tools such as the Michigan Screening Test, or the Comprehensive Drinking Profile may be used to determine the most therapeutically benefical course of action for the veteran. Upon completion of the screening phase, the staff of Two Worlds will contact the Coordinator, ADTP Inpatient or his designee for determination of a bed date for admission. During the inpatient treatment phase and in aftercare, the staff or counselor or Two Worlds will be the

patient case manager. The veteran remains court committed to Two Worlds throughout all phases of treatment. Two Worlds in referring this veteran to ADTP, VAMC, will make all efforts to forward a Health Certificate from the PHS/IHS Hospital and any available information regarding the patient, including assessments, to the Coordinator, Inpatient ADTP. Some determination must be made regarding the veteran's ability to take care of his own personal needs and to be medically stable or able to participate in the inpatient program.

c. VAMC ADTP. The ADTP Coordinator will make every effort to provide a bed date as soon as possible after the evaluation process has been completed. The patient will remain in treatment at ADTP for the length of time necessary for successful program completion, usually 28 days. The social worker will provide Two Worlds with a summary of the patient's course of treatment and suggested aftercare plans for that patient. The veteran will need to sign releases authorizing this information be released. In coordination with the counselor at Two Worlds, suggested aftercare plans might include referral to a transitional living unit or halfway house. If these units or houses are under VA auspices, it will be the responsibility of the Two Worlds to inform the Tribal Court of these recommendations and to handle whatever is necessary with them surrounding the issues of a Tribal Court commitment.

/s/

ROBERT W. YOUNG, ACSW
Chairman
Indian Advisory Sub-Committee


Native American Veteran
with Alcohol/Drug Problems
Tribal Court System
Commitments for
Alcohol Treatment
All Indian Pueblo Council
"Two Worlds"
Coordinator &
Case Manager
1. Assessment
2. Referral
3. Follow-up
IHS/PHS Hospital
DETOX or Medical
Certificate
Aftercare
Veterans Administration Medical Center
Inpatient Treatment Program - ADTP
Other Inpatient
or Outpatient
Treatment Programs
Transitional
Living Unit or
Half-Way House

APPENDIX F

VETERANS ADMINISTRATION ADVISORY COMMITTEE ON NATIVE AMERICAN VETERANS

1. Ted Bryant
   Principal-In Charge
   T3RC Associates
   Greenwood Village, Colorado 80111

2. Niles C. Cesar
   Executive Vice-President
   Southeast Alaska Regional Health Corporation
   Juneau, Alaska 99801

3. Robert K. Chiago
   Deputy Assistant Director
   Arizona Dept. of Economic Security
   Phoenix, Arizona 85005

4. Raymond C. Field, Chairman
   VA Advisory Committee on Native American Veterans
   Silver Spring, Maryland 20910

5. Thomas M. Holm, Ph.D.
   Associate Professor
   American Indian Studies
   University of Arizona
   Tucson, Arizona 85721

6. Mark Jacobs, Jr.
   Vice President
   Alaska Native Brotherhood
   Sitka, Alaska 99835

7. Joe L. Jojola
   Project Director
   The "Two Worlds" Project
   All Indian Pueblo Council, Inc.
   Albuquerque, New Mexico 87197-6507

8. Robin A. LaDue, Ph.D.
   Clinical Psychologist
   Puget Sound Associates
   Renton, Washington 98055

9. John V. Meyers
   President, Tribal Funding Development
   and Management Corporation
   Washington, D.C. 20037

10. Andrew Montano
Director
VA Medical Center
Albuquerque, New Mexico 87108

11. Frank M. Montour
Outreach Specialist
Vet Center
Lincoln Park, Michigan 48146

12. Bill Pearson
Director
V A Regional Office
Muskogee, Oklahoma 74401

13. Enos Poor Bear, Sr.
Martin, South Dakota 57551

14. Bill Prince
Deputy Assistant Secretary
Veterans' Employment & Training
U. S. Department of Labor
Washington, D. C. 20210

15. Tony Secatero
National Service Officer
AMVETS
Albuquerque, New Mexico 87103

16. David T. Ortega Shaw
Assistant Director/Program Counselor
Veterans Upward Bound Program
Office of Veterans Affairs
Humboldt State University
Arcata, California 95521

17. Lawrence Snake
Vice-President, Delaware Tribe of Western Oklahoma
Midwest City, Oklahoma 73110

18. Arthur Thomas (Retired 10/87)
Director
Division of Tribal Affairs
Indian Health Service
Rockville, Maryland 20857

19. Ms. Luana Reyes
Associate Director
Office of Planning, Evaluation & Legislation
Indian Health Service
Rockville, Maryland 20857

STATEMENT OF
THOMAS E. COLLINS
ASSISTANT SECRETARY OF LABOR
FOR VETERANS' EMPLOYMENT AND TRAINING
BEFORE THE
SENATE SELECT COMMITTEE ON INDIAN AFFAIRS

November 14, 1989

Mr. Chairman and Members of the Committee:

Thank you for inviting me to present the views of the Department of Labor on the employment needs and problems of Native American Indian veterans and our efforts to address them. I am joined today by John V. Meyers, the newly appointed Deputy Assistant Secretary for Veterans' Employment and Training. John is a Native American veteran who has served as a member of the Department of Veterans Affairs Advisory Committee on Native American veterans.

According to the Department of Veterans Affairs estimates, more Native Americans serve in the armed forces than the proportion of the overall population. There are about 170,000 Native American veterans, representing over 12 percent of the American Indian population, and many of them experience severe unemployment. Those living on reservations have an unemployment rate of about 35 percent with highs of up to 80 percent on some reservations. Off reservations, the unemployment rate for these veterans is estimated in the 15 to 20 percent range.

Native American Indian reservations offer few opportunities for productive careers and far too little economic opportunity to meet the needs of their people. Efforts on the part of Federal programs to stimulate economic development depend on the cooperation and support of local governments to carry them out, and their success depends on the entrepreneurial, management and executive skills of Native Americans to carry out development projects.

Our efforts to assist Native American veterans to find jobs and obtain training is inseparably tied to economic development in their communities. The Veterans' Employment and Training Service does not have a direct mandate to develop the economic base and create jobs. Our programs and other activities mandated by law are restricted to employment and training activities for veterans. Some of these serve specific targeted veteran subgroups exclusively, with several of our programs targeted to serve Native American veterans.

The Local Veterans' Employment Representatives (LVER) program and the Disabled Veterans' Outreach Program (DVOP) provide grant funds for personnel in State Employment Service offices across the country. Although those offices must provide priority services to veterans by law, the LVER and DVOP staff serve veterans exclusively and have received professional training in

vocational guidance and counseling, veterans' reemployment rights, benefits, entitlements, and other training to provide quality assistance to veteran applicants.

My office also administers the employment program dedicated specifically to veterans under the Job Training Partnership Act (JTPA), Title IV, Part C (IV-C). The IV-C program funds training, such as classroom and on-the-job training, and other employment-related assistance. Our Homeless Veterans' Reintegration Projects (HVRP) are funded by the Stewart B. McKinney Homeless Assistance Act and provide for outreach workers to find and help homeless veterans obtain employment. All of these activities focus on helping veterans find jobs or move into better jobs.

For several years the Veterans' Employment and Training Service has undertaken efforts to address the employment problems of our Native American veterans. Over the past few years, we have intensified these efforts and broadened the types of approaches we are undertaking to discover new solutions to their employment problems.

Our Title IV-C program for the current year includes American Indian veterans. Although the program restricts the funding of positions which duplicate the efforts of our Disabled Veterans'

Outreach Program specialists and Local Veterans' Employment Representatives, exceptions are made in those cases where outreach activities are being conducted to serve Native American veterans.

Our Title IV-C program in Wyoming provides special outreach services to the Wind River Reservation where unemployment among Native American Indian veterans may be as high as 90 percent. The program enrolls the veterans in a mix of remedial education, classroom, and on-the-job training. The State Employment Security Agency has also committed a Disabled Veterans' Outreach Program specialist to serve on this very large reservation. Our staff in Arizona and New Mexico have been working with the Navajo Nation and other tribes having a common border with these two States. Recently the State of Arizona provided a full-time Local Veterans' Employment Representative and four part-time positions on the Navajo reservation. We recently added special funding to New Mexico to provide training to Native American Indian veterans.

In Hawaii an outreach program was undertaken two months ago jointly by the Department of Veterans Affairs, the State Veterans Department, and our office to develop more outreach activities targeting Native Hawaiian veterans for training and job placement activities. The program plans to make use of the VA's Vet

Centers as a single point of contact for services from all three cooperating agencies.

In August 1988, we funded the development of a handbook for employment and training service providers entitled, "The American Indian Veteran: Perspectives and Methods to Provide Employment and Training Outreach." This culturally attuned handbook provides advice on improving ethnic relations in the effort to assist Native American veteran constituents.

We awarded a $200,000 grant to the National Congress of American Indians in May 1986 to promote entrepreneurship as a way to develop jobs for Indian veterans. Working closely with the Small Business Administration, this project conducted business development seminars in States with relatively high Indian veteran populations.

In 1984, we contributed $50,000 to the Presidential Commission on Indian Reservation Economies.

We have been an active participant of the Department of Veterans Affairs Advisory Committee on Native American Veterans and endorsed the committee's report, particularly the recommendation that a National Native American Veterans Coordinating Council be established. Because unemployment for these veterans usually

reflects multiple problems not normally addressed by Title IV-C employment and training programs, -- such as medical and psychological problems, substance abuse, family conflicts, legal hassles, obstacles to obtaining benefits and entitlements -- coordinating our efforts with other agencies and supportive services is essential to solving the unemployment problems of our Native American veterans. In many cases, these problems must be addressed before the veteran can receive any employment-related services. The Coordinating Council will be able to create solid, formal commitments to put this into practice wherever it is appropriate. It would also be able to promote economic development activities on the part of other agencies.

On and off the reservations, our Native American Indian veterans need special attention and I intend to continue to commit our program plans to developing effective methods to address their severe employment problems.

This concludes my statement. Thank you again for the opportunity to discuss the problems of these veterans and what we are doing to assist in their resolution. I will be pleased to answer any questions you have on this matter.

IHS TESTIMONY BEFORE THE SENATE SELECT COMMITTEE ON INDIAN AFFAIRS' NOVEMBER 14, 1989 OVERSIGHT HEARING ON NATIVE AMERICAN VETERAN'S ISSUES

Mr. Chairman and Members of the Committee, I am Dr. Stephen Permison, Director, Patient Care Policy, Indian Health Service. I am pleased to be here today to discuss with you the efforts of the Indian Health Service (IHS) to meet the needs of Native American veterans.

The IHS is the Federal Agency charged with administering the principal health program for American Indians and Alaska Natives. The goal of the IHS is to raise the health status of the approximately 1 million American Indian and Alaska Native people to the highest possible level. This goal encompasses all Indian and Alaska Native people, including those who are veterans. IHS's mission is threefold 1) to provide or assure the availability of high quality, comprehensive, and accessible health services; 2) to provide increasing opportunities for Indians to manage and operate their own health programs; and 3) to serve as a health advocate for Indian people. To help accomplish these objectives, the FY 1990 Interior Appropriations Act provides IHS approximately $1.2 billion for clinical, preventive and other program support services.

In the new fiscal year the IHS will continue to focus on quality assurance, community based comprehensive care and the commitment to support activities that reduce health risk factors as well as treat diseases. IHS is also continuing to increase its emphasis on the strengthening of the tribal health care delivery systems. This is a key factor in examining new or improved cooperative arrangements that meet the needs of any Indian community or special group, such as Indian veterans.

Presently, a variety of associations currently exist between the Veterans Administration (VA) and the Indian Health Service (IHS). These associations are identified at both the IHS Area and the individual IHS facility level.

At the facility level, the IHS, through existent interagency agreements, utilizes many inpatient and outpatient services offered by the VA. The reverse utilization of IHS facilities by the VA or their beneficiaries is less prevalent.

The IHS recently has received the authority to provide and bill non-Indian Veterans and other non-IHS beneficiaries for health services provided at IHS facilities. This authority is provided pursuant to Public Law (P.L.) 100-713, the Indian Health Care Amendments of 1988, which amended the Indian Health Care Improvement Act of 1976 (P.L. 94-437). The Secretary is authorized to provide health services to these otherwise ineligible persons in an IHS facility and who reside within the service area of an IHS service unit if the affected Indian tribe(s) agrees that the identified facility may open its doors to non-IHS beneficiaries. In addition, the Secretary and the Indian tribe(s) must have jointly determined that the provision of health services to such persons will not result in a denial or diminution of health services to eligible Indians, and that there is no reasonable alternative health facility or services, either within or outside the IHS service unit available to meet the health needs of such individuals. Where the health facilities are operated under a contract with the IHS pursuant to the authority of the Indian

Self-Determination and Education Assistance Act (P.L. 93-638) the governing body of the tribe or tribal organization providing health services under the contract may decide to open its doors to ineligibles based on these same considerations. To date, no tribes have utilized this authority.

The Indian Self-Determination and Education and Assistance Act of 1975 (P.L. 93-638) provides for the transfer to tribes of functions that have been previously performed by the Bureau of Indian Affairs (BIA) and the IHS, including the provision of health services.

On October 5, 1988, the President signed the Indian Self-Determination and Education Assistance Act Amendments of 1988, P.L. 100-472. This Act amends enhance the ability and desirability of tribal governments to assume responsibility for providing federal services to their members. These amendments could result in a significant increase in the number of IHS direct care facilities being operated through "638" contracts. As these tribal health care providers compete with the private sector for the provision of health care services, factors such as expediency and cost efficiencies should encourage a broader exchange of services.

Beyond the facility level, service areas within the IHS have also developed a variety of shared resource agreements. Such arrangements are fueled not only by economic necessity but also by the professional advantages reaped through the intermingling of health delivery staff.

Some examples are the credentialing of IHS physicians at VA hospitals; mutually developed and shared continuing Medical Education; and the shared utilization of hospital labs, x-ray and other support systems. This is only a sampling of currently shared services. A more extensive catalogue of these shared services is under preparation and it is expected to be finalized soon.

The IHS has also carefully designed its overall patient registration system to maximize its use in planning on the local, regional and national levels for the provision of an array of health services to its constituent's. Recently, IHS has modified its patient registration system to include Indian veterans. This modificiation has improved the ability of IHS to identify Indian veterans so that it can better plan and coordinate for the sometimes special needs of this group. An important aspect of the patient registration system is to provide IHS with information as to what third-party resources a patient might be entitled. For example, a patient might be eligible for state health benefits, medicare/medicaid assistance or VA benefits and assistance. In this way, IHS's ability to coordinate needed health care for the patient with the most available and appropriate sources of care is greatly enhanced.

Since IHS provides a comprehensive array of services, ranging from preventive education, clinical care, and safe water systems, an Indian patient receiving such services is often involved in a continuum of care not normally provided through other health care systems. However, as in the case of the Veterans Administration (VA) medical services, they are better able to provide specialized or otherwise appropriate care that

would not be so readily available through IHS's system. Such examples include burn treatment, prosthetic and physical rehabilitation/therapy, or other trauma-related treatment that does not occur with any prevalency in any one Indian community.

IHS is committed to seeking ways of improving its services to all Indian people. Within IHS's target population, veterans have a most special place and deserve assurances that their unique needs will be identified and properly treated. The decision on what treatment is most proper must be accomplished in a manner that fully considers the quality and effectiveness of the care available to him or her. IHS intends to continue to fully explore and promote those actions necessary to accomplish this goal.

This concludes my prepared statement. I will be happy to respond to any questions that you may have.

STATEMENTS OF

R.J. VOGEL

CHIEF BENEFITS DIRECTOR

DEPARTMENT OF VETERANS' AFFAIRS

BEFORE THE

SELECT COMMITTEE ON INDIAN AFFAIRS

U.S. SENATE

NOVEMBER 14, 1989

Mr. Chairman and Members of the Committee:

My colleagues and I are pleased to be here this morning to provide testimony on VA programs and efforts to meet the needs of Native American veterans.

As you know, the VA is a cabinet-level department responsible for administering a broad spectrum of benefits to assist eligible veterans, their dependents, and survivors. Literally millions of veterans look to VA each year for services ranging from psychological counseling to education benefits.

Let me simply offer a profile of some of our major benefit programs. I am directly responsible for many of these programs as the head of our Veterans Benefits Administration while

many others fall under the operational responsibility of my colleague Dr. Arthur Lewis here beside me. As I will also explain in more detail, some of the most far-reaching VA initiatives related to service-delivery to native Americans are under the leadership of Mr. Allen Clark, our Assistant Secretary for Veterans Liaison and Program Coordination whom I'm also pleased to have beside me.

Among the key programs we administer in the benefits area, for example, are the following:

- o Compensation....to veterans disabled by injury or disease incurred or aggravated during active service...and Dependency & Indemnity Compensation (DIC)...to survivors of service personnel or veterans who died from a disease or injury incurred or aggravated during active service. Approximately 2.5 million beneficiaries will receive approximately $11 billion this year.

- o Pension....to wartime veterans with limited income who are permanently and totally disabled for reasons not traceable to service...and to

their survivors. Approximately 1.2 million beneficiaries will receive $3.9 billion.

- Education and training....under seven different programs, about $1 billion...will be paid to over 460 thousand beneficiaries.

- Vocational rehabilitation...payment of a subsistence allowance and costs associated with a vocational course are provided to service-disabled veterans. This year, over 26 thousand veterans will participate.

- Home loan credit assistance....to eligible veterans, active duty service-persons and certain surviving spouses seeking to buy, build, refinance or repair a home, condominium or mobile home...will benefit over 176 thousand veterans this year, plus their families.

- Life insurance....protection for the Nation's servicepersons and veterans is provided under nine separate programs. This year, there will

be 7.1 million policies in force under these programs, valued at over $213.3 billion.

- Veterans assistance....concerning these and other VA programs is provided through over 11 million telephone or personal contacts annually. Supervision of the estates of incompetent beneficiaries, outreach, and dissemination of information materials are included among the specialized activities of Veterans Service Divisions in all of our regional offices.

- Burial benefits....in the form of burial and plot allowance, flags, headstone markers, gravliners...are provided to certain veterans and their dependents...at an approximate cost of $148.7 million.

- Special disabled veterans benefits....include clothing allowances to service-disabled veterans who wear prosthetic or orthopedic appliances or are confined to wheelchairs which wear out or tear clothing; grants of up to $35,500 to certain disabled veterans who may be entitled under

certain conditions for building, buying or remodeling a home specially adapted to their needs; automobiles or adaptive equipment for the safe operation of a vehicle.

In the health care arena, VA provides a continuum of care to eligible veterans through our 172 medical centers, 236 outpatient clinics, and 28 domiciliaries. Our programs range from providing acute hospital care to domiciliary and nursing home care, community based services and outreach programs. In FY 1989, for example, VA provided care to some 1.1 million inpatients, and logged some 22.6 million outpatient visits. VA provides many important specialized treatment programs as well, including readjustment counseling for Vietnam veterans through 196 outreach centers and substance abuse treatment through programs at 150 of our facilities. Relatively new initiatives have been developed to treat homeless chronically mentally ill veterans, veterans suffering with AIDS, and post-traumatic stress disorder.

VA recognizes that native American and other veterans may live considerable distances from our VA medical centers. Our health care system, however, has made headway in serving these rural areas and such target groups as native American veterans through several mechanisms. Among these,

-- We have activated 111 outreach clinics in the last four years (for a total of some 160). These are either small outposts or part-time services in which VA medical staff travel in a mobile clinic or in teams to provide services to Veterans in their own communities.

-- We have also established some 53 community-based clinics to serve less populated areas with primary and post-hospital care. These clinics are physically separate but administratively attached to a VA medical center.

-- In establishing community-based counseling centers for Vietnam-era veterans (so-called "Vet Centers"), we have tailored their outreach and mix of services in relation to local need. And many of those located in proximity to native American populations have developed outreach and counseling initiatives to service these veterans and their families. Establishment of four new Vet Centers in Hawaii, for example, has significantly increased service availability for Native Hawaiian and Asian American Veterans. In order to improve outreach and service delivery,

Readjustment Counseling Service (RCS) also established a Native American Working Group in 1983 and an Asian American/Pacific Islander Working Group in 1989.

-- Through a number of programs we also contract for care in or near the veteran's community.

Overall, VA programs have a far-reaching national impact on veterans generally as well as on native American veterans. In serving millions of veterans annually, we must, however, be cognizant of, and responsive to, the needs of diverse, though sometimes overlapping groups. These include veterans with service-incurred disabilities, the growing population of aging veterans, women veterans, Vietnam veterans, former prisoners of war, and homeless veterans, to name only a few who have a distinct and rightful claim to VA's attention and concern. The often diverse needs of the many groups we serve present real and sometimes formidable challenges, particularly in times of fiscal constraint and competing demands for resource commitments.

In that regard, we are sensitive to the special needs and concerns of native American veterans, and are indebted to the work of the VA Advisory Committee on Native American Veterans

for their significant contribution to our Department. Authorized under Public Law 99-272, the Committee was established for the purpose of examining and evaluating programs and other activities of the Veterans Administration with respect to the needs of native American veterans, including American Indians and Alaska Natives. Public Law 100-322 extended the Committee until July 1, 1989, to allow for examination of the needs of Native Hawaiian veterans.

The principal findings and recommendations of the Committee provide a clear agenda for the Department of Veterans Affairs and sister Federal Departments serving native American veterans. Major issues identified and addressed by the Committee included:

1. Problems of service availability, access, and utilization for native American Veterans.

2. Need to expand and coordinate interdepartmental/agency efforts to ensure an integrated and effective government-wide response to serving native Americans.

3. Coordination of Federal agency efforts with tribal, state and local government and the private sector in addressing

major problems of health, education, housing, economic development, and employment.

Let me focus, in that connection, on what I believe is perhaps the most important of the Advisory Committee's recommendations -- that VA establish a National Native American Veterans Coordinating Council. The committee recommended that such a body be composed of representatives from VA, Indian Health Service, the Bureau of Indian Affairs, the Department of Labor, the Department of Housing and Urban Development and the Indian community for the purpose of joint planning, establishing policy for interagency collaboration, developing legislative initiatives, and facilitating field recommendations.

VA agrees with the Committee that there is a clear need for Federal agencies to coordinate programs and resources in providing services to native American veterans. Let me note that VA has been pleased to be an active participant on the White House Native American Indian Interagency Task Force, which was recently formed to facilitate communication and information sharing among all Federal departments providing services to native Americans. This important Administration effort provides a forum for addressing major issues and has

highlighted the need for a central point of coordination for service provided to native American veterans. Coordination and communication among the involved agencies would facilitate the more efficient delivery of services to the underserved population and hopefully would assist in the resolution of long-standing problems, including gaps in service. I am pleased to report in that regard that Secretary Derwinski initiated plans to establish a Council on Native American Veterans to promote and coordinate Federal programs and services for native American veterans. Departmental responsibility for the Council has been assigned to the Office of Mr. Allen Clark, VA's Assistant Secretary for Veterans Liaison and Program Coordination, and requests for participation have been sent to other Federal agencies serving native American veterans.

We view this new entity as important not simply because it will help assure that diverse Federal efforts are better coordinated, but because we believe that no one Department or Agency can do enough to solve such profound problems as unavailability, inaccessibility and underutilization of services, as described by the Committee. We believe the timing

is right to build on the work of the Advisory Committee and to capitalize on the momentum and interest among the Federal partners which the Committee identified.

Moreover, we believe this strategy is particularly sound in the present budget environment in which we must explore opportunities for sharing resources, developing interagency agreements, and similar means to work together on service delivery.

We concur as well with the Committee's recommendations that coordinating councils be established on both local and area-wide levels. Developing such structures -- some of which are already in place -- is, in our view, the soundest way to assure that VA and other involved agencies can ultimately achieve greatest effectiveness.

All of this is not to say VA has not had real success in the delivery of services to native American veterans. Let me cite a few examples:

Outreach - Our benefits programs which are administered through 58 regional offices are all supported by Veterans Assistance Services. Their work is essentially outreach. My field

managers recognize the importance of outreach and I've found that most of those stations serving significant native-American populations have outreach efforts which are either planned or ongoing. By way of illustration, our Cheyenne Regional Office began its effort by placing a VA employee on the reservation to deliver benefits information, but this approach failed because of distrust and cultural disparity. The position of Tribal Service Officer was developed to overcome these problems. A Federal grant was obtained through the Job Training Partnership Act and a partnership was formed between the Department of Labor, Veterans Employment and Training Administration, Wyoming Job Training Administration and the Veterans Administration. This program is well received by native Americans and the Tribal Service Officer is usually kept busy. In Alaska, outreach efforts are further complicated by the State's sheer size, climate and remote nature of the area. Outreach is hampered by the lack of tribal groupings as epitomized by the Eskimos, who have no tribal structure. Still there is a significant outreach effort that includes pamphlet distribution to rural areas, development of expanded 800 lines, interaction with civic groups, personal visitation and Veterans Service Organization involvement with the Private Industry Council in attempts to find jobs for unemployed native Americans. Although I've directed each of my 58 regional offices to mount

efforts at outreach to native American veterans, our field experience suggests that regional, tribal, and cultural differences among native Americans make it inadvisable for us to superimpose a specific outreach formula. We are, instead, encouraging our offices to tailor an approach to fit the needs and concerns of the local groups.

Local Advisory Committees. Several of our facilities have established local committees through which native Americans provide advice or coordination in connection with ongoing or planned programs. For example, VAMC Hot Springs, SD, has established a Native American Advisory Committee; has developed and implemented a sharing agreement with the IHS hospital in Pine Ridge, and has been meeting with IHS representatives to plan and coordinate provision of inpatient and outpatient services for our joint constituents on the surrounding Sioux reservations. Our Honolulu Regional Office/Outpatient Clinic has developed a committee for Hawaiian and Pacific Island Natives and is working jointly with the Office of Hawaiian Affairs for the State of Hawaii in developing special medical center programs and outreach efforts.

VAMC Albuquerque, NM, has an established Indian Advisory Committee with Federal agency, tribal, state and local representation. In addition, an Outreach Program has been

established at Gallup, NM, and joint planning between VA & IHS resulted in VA outreach staff being assigned to the seven IHS hospital sites on the Navajo Reservation. A VA social worker has been outplaced to provide outreach and liaison to Pueblos located along the Rio Grande River, and the position of Native American Coordinator has been established at the Medical Center to coordinate program efforts and exchange of medical information between VA & IHS. And in Alaska, a statewide intergovernmental coordinating effort--the Alaska Native Veteran Council--was organized this year to expand availability and access to services for native Alaskan veterans. VA assumed a leadership role in this joint effort with Alaska Native Health Service, IHS, BIA, Dept. of Labor and Alaska Dept. of Military and Veterans Affairs. Activities have focused on sharing of agency information systems and developing strategies for communicating service information and facilitating coordination at the village level. This group was formed as a direct result of consultation and recommendations of the VA Advisory Committee on Native American Veterans during its meeting in Anchorage in September 1988.

Special Treatment programs. VAMC American Lake, WA, has designated beds within the Post Traumatic Stress Treatment and Homeless Domiciliary Care Programs for treatment of native

American veterans. Plans are underway to admit cohort groups of native American veterans for PTSD during 1990; collaborative planning is in process to incorporate native American healing into this program. The facility is a member of the newly formed Northwest Indian Veteran Association, and a PTSD training program for native American professional staff is being planned.

Several of our medical centers have also instituted sharing agreements with the Indian Health Service, some of long-standing such as at our Tucson and Prescott, AZ medical centers and others just coming on line, such as at Spokane, WA and Asheville, N.C.

I offer these capsules not as a catalogue of all our initiatives but simply to highlight by way of example. Let me say, in that regard, that VA takes pride in our records of success and in the spirit of caring which marks so much of our work. Yet we remain mindful that past and ongoing successes must not mask challenges that still lie before us.

Among the concerns expressed by the VA's Advisory Committee, for example, was the need for much better statistical data regarding native American veterans.

26-623 - 90 - 8

(Attached, are statistical briefs which provide some limited data on native American veterans in relation to VA programs.) We agree that more data is needed for most effective planning efforts (as well as to be able to identify the extent and level of services provided native American veterans under all of our programs). VA has, however, explored other information systems, and will continue to do so. Moreover, we believe additional data will emerge from surveys on native Americans being carried out under the auspices of the National Center for Health Services Research as well as data collection efforts of the Indian Health Service.

We believe that VA has played an important role in providing benefits and services to native American veterans. But the findings of our Advisory Committee highlight that there remains much to do. While we have taken important steps forward, we intend to continue to work with other Government agencies and native American representatives on the Federal, State, and local levels to continue the progress we've made.

Mr. Chairman, that concludes my formal statement, but my colleagues and I would be pleased to respond to any questions you may have.

INTRODUCTION

This publication is designed to disseminate demographic and socioeconomic data on native American veterans. Information in this report is based on data obtained from the 1980 Census of Population. The Bureau of the Census prepared a series of public use microdata tapes containing information from the 1980 Census from a sample of all people in the general U.S. population with identifying characteristics removed. Figures shown in this report are based on a one-percent microdata file, therefore numbers may vary slightly from data based on the full 19-percent sample published by the Bureau of the Census. Due to the possible sampling error in data drawn from the one-percent microdata file, the variables discussed in this report have been examined individually. Also, no comparisons have been made between veterans and nonveterans.

This report includes American Indian, Aleut, and Eskimo veterans, with American Indians representing over 97 percent of the total. Therefore, unless otherwise stated, the term native American veterans will refer to all three groups of veterans.

HIGHLIGHTS

On April 1, 1980, the number of living native American veterans was estimated at 159,900, a sum representing only 0.4 percent of all veterans in civilian life. Native American veterans were noticeably younger as a group than were veterans as a whole. Their median age of 42.4 years was some 7.2 years below that of the total veteran population. About 44.7 percent of native American veterans were under 40 years old, 49.5 percent were 40-64 years of age, while only 5.8 percent were at least 65 years old.

Four of every five native American veterans (80.1 percent) served during one or more war periods. Among individual periods of service, 36.4 percent of native American veterans served only during the Vietnam era, 27.8 percent were survivors of World War II, and 11.2 percent participated only during the Korean conflict. Peacetime-only veterans accounted for 19.9 percent of the native American veteran population count on April 1, 1980, and the vast majority of these had been on active duty only between the Korean conflict and the Vietnam era.

As of April 1, 1980, more than three of every five native American veterans (69.3 percent) were married, 12.9 percent were divorced, 11.8 percent had never been married, while the group of veterans who were widowed and those who were separated each accounted for 3 percent of the total. Veterans the most likely to be married were those ranging in age from their mid-twenties to their mid-forties (79 percent).

Approximately 36.2 percent of the native American veteran population had graduated from high school but had gone no farther, 32.4 percent had at least some college, and the remaining 31.4 percent had less than 12 years of education.

Slightly more than three of every four veterans (77.2 percent) were in the labor force on April 1, 1980, with some 67.9 percent actually employed. The majority (62 percent) of the veterans who held jobs in 1979 worked full-time (50-52 weeks). The remaining 38 percent of those who held jobs sometime during 1979 worked less than 50 weeks.

Roughly 12 percent of all native American veterans who reported income activity in 1979 earned $25,000 or more, somewhat under one-half (44.9 percent) earned $10,000 to $25,000, and the remaining 43.1 percent earned less than $10,000. The median income for veterans who reported income activity in 1979 was $11,900.

SB 70-85-3
October 1985

Office of Information
Management and Statistics
Statistical Policy and Research Service
Research Division (711)

Native American veterans who lived in California (27,300) or Oklahoma (18,300) together represented 30 percent of all native American veterans living in the United States. In California, native American veterans represented 0.9 percent of that state's total veteran population, while in Oklahoma they represented 4.5 percent of the veterans.

SELECTED DATA ON NATIVE AMERICAN VETERANS

Age	Number of Veterans
All Ages	159,900
Under 25 years	12,100
25-29 years	17,100
30-34 years	24,900
35-39 years	17,400
40-44 years	17,600
45-49 years	17,700
50-54 years	17,000
55-59 years	15,600
60-64 years	11,100
65-69 years	8,100
70-74 years	2,400
75 years and over	2,900
Median Age: 42.4	

Period of Service	Number of Veterans
Total	159,900
Wartime: total	129,000
Vietnam era: total	62,100
No Service in Korea	38,200
Korean conflict: total	29,700
No Service in World War II	24,300
World War II	46,500
World War I	1,000
Peacetime: total	31,900
Post-Vietnam era	10,100
Service between the Korean conflict and the Vietnam era	19,300
Other Peacetime	2,300

Educational Attainment	Number of Veterans
Total	159,900
Elementary: 0 to 8 years	23,200
High School:	
1 to 3 years	28,900
4 years	57,900
College:	
Less than 4 years	36,400
4 years	7,700
5 or more years	5,800

Income in 1979	Number of Veterans Reporting Income Amount
Total	133,800
$0 or loss	400
$1 to $4,999	13,300
$5,000 to $7,499	17,700
$7,500 to $9,999	14,900
$10,000 to $12,499	28,200
$12,500 to $14,999	21,200
$15,000 to $24,999	31,600
$25,000 to $34,999	11,900
$35,000 to $49,999	4,300
$50,000 or more	2,300

Marital Status	Number of Veterans
Total	159,900
Married	110,900
Never Married	18,900
Widowed	4,800
Separated	4,800
Divorced	20,600

Employment Status	Number of Veterans
Total	159,900
In the Labor Force	123,400
Employed	108,600
Unemployed	14,800
Not in the Labor Force	36,500

Weeks Worked	Number of Veterans Who Worked in 1979
Total	129,900
1 to 13 weeks	9,600
14 to 26 weeks	9,700
27 to 39 weeks	13,000
40 to 47 weeks	12,100
48 to 49 weeks	4,900
50 to 52 weeks	80,600

To obtain copies of this report, contact Betty Pasco, (202) 389-2121. Inquiries about the substance of the report should be directed to the author:

Wandakay J. Wells, Management Analyst
Research Division (711)
Statistical Policy and Research Service
Telephone: (202) 389-3980

Office of Information Management and Statistics
Veterans Administration
810 Vermont Avenue, N.W.
Washington, DC 20420

Veterans Administration

Statistical Brief

Native American Veterans' Usage of VA Hospital Care

Introduction

The purpose of this statistical brief is to disseminate recent data on VA hospitalizations of native American veterans (i.e., American Indian, Aleut, and Eskimo veterans).

The data in this statistical brief were obtained from two sources - the 1986 VA Patient Treatment File (PTF) and the 1986 VA Annual Patient Census (APC). The 1986 PTF 1/ is an automated file of the medical records of patients discharged from VA medical centers during fiscal year 1986 (October 1, 1985 - September 30, 1986); the 1986 APC 2/ is an automated file of the medical records of patients who were on the rolls in VA medical centers as of September 30, 1986, and who were subsequently discharged. 3/ The 1986 PTF provides an overview of VA medical center usage during fiscal year 1986, and the 1986 APC provides a "snapshot" view of VA medical center usage as of a specific day in the fiscal year (i.e., September 30, 1986, the last day of fiscal year 1986).

Highlights

During fiscal year 1986, a total of 4,366 native American veterans were discharged from VA hospitals. This figure represents only 0.4 percent of all fiscal year 1986 VA hospital discharges (which totalled 1,055,251). Also, only 220 native American veterans were on the rolls in VA hospitals as of September 30, 1986, representing just 0.4 percent of all patients in VA hospitals on that day (which totalled 55,358). The paucity of native

1/ *If a veteran has more than one episode of hospital care during the fiscal year, the PTF contains a seperate record pertaining to each hospital discharge of that veteran during the year.*

2/ *PTF and APC records contain many but not all of the same data elements for a given patient.*

3/ *Patients who were on the rolls in VA hospitals as of September 30, 1986, and who were subsequently discharged are not only included in the 1986 APC but will also be included in the 1987 PTF.*

SB-70-87-1
July 1987

Associate Deputy Administrator
for Management
Office of Information Management
and Statistics
Statistical Policy and
Research Service
Biometrics Division (712)

American veterans using VA hospitals as indicated by these data is related, of course, to the fact that native American veterans comprise only about 0.6 percent of all veterans in civilian life. 4/ 5/

Nearly 75 percent of all VA-hospitalized native American veterans in 1986 were hospitalized in VA medical centers located in the Midwest, West, or Southwest. Of course, this fact is related to the basic demographics of native American veterans; most native American veterans reside in the Midwest, West, or Southwest. In fact, about four-fifths of VA-hospitalized native American veterans during fiscal year 1986 were residents of just thirteen states. To highlight a few, 24 percent of VA-hospitalized native American veterans in 1986 were residents of South Dakota, 12 percent were residents of Oklahoma, seven percent were residents of Montana, six percent were residents of Arizona, and five percent were residents of California.

More than half of all native American veterans who used VA hospitals in fiscal year 1986 were under age 55, so that native American veteran VA hospital users are younger, on the average, than VA hospital users overall. 6/ 7/

As of fiscal year 1986, and based on counts of patients discharged from VA medical centers, approximately one-third of all native American veteran VA hospital users were veterans of World War II, slightly more than one-quarter were veterans of the Vietnam era, and about one-sixth were veterans of the Korean conflict. The remainder were veterans of other periods of service. Among VA hospital users overall, and on a percentage basis, there are relatively more World War II veterans and relatively fewer Korean conflict and Vietnam era veterans.

During fiscal year 1986, about 30 percent of all VA-hospitalized native American veterans reported having military service-connected medical conditions, but most (92 percent of) VA-hospitalized native American veterans were treated for nonservice-connected medical conditions. Among VA hospital users overall, about 30 percent reported a service-connected disability, while 90 percent were treated for nonservice-connected conditions.

About 41 percent of VA-hospitalized native American veterans in 1986 were married, a similar percentage (41 percent) reported that they were either divorced, separated, or widowed, and about 17 percent reported that they were single (never married.) Among VA hospital users overall, a greater percentage are married (53 percent), a smaller percentage are divorced, separated, or widowed (33 percent), and a smaller percentage are single (13 percent.)

Nearly all (98 percent of) VA-hospitalized native American veterans in 1986 were male veterans; two percent were female veterans. This corresponds closely to the pattern among VA hospital users overall.

During fiscal year 1986, most (85 percent of) VA-hospitalized native American veterans were hospitalized for 30 days or less, which is similar to the pattern for VA hospital users overall (87 percent.)

Among VA-hospitalized native American veterans in 1986, the most frequent primary diagnoses upon discharge from the hospital were: (1) alcohol dependence and abuse, (2) factors other than diseases or injury (such as exposure to communicable diseases, family history influencing risk of disease, etc.), (3) heart diseases, (4) digestive diseases other than abdominal hernias or cirrhosis of the liver, and (5) injuries and poisonings. In comparison, the most frequent primary discharge diagnoses among VA hospital users overall were: (1) heart diseases, (2) malignant neoplasms, (3) psychoses other than drug or alcohol-related, (4) external causes of injury and poisoning, and (5) diseases of the digestive system other than abdominal hernias or cirrhosis of the liver.

4/ Veterans Administration, Office of Information Management and Statistics, Native American Veterans, SB 70-81-1, Washington, DC, October 1985.

5/ Data in the report, "Native American Veterans", are estimates derived from the 1980 Decennial Census of Population and are as of April 1, 1980. It is estimated that on April 1, 1980, there were 119,900 native American veterans in civilian life.

6/ The 1986 VA Administration's Annual Report shows that only about 14 percent of all patients discharged from VA hospitals in fiscal year 1986 were under age 55.

7/ Overall VA hospital usage data cited for comparison in this report are taken from the 1986 VA Administration's Annual Report.

Selected Data on Native American Veterans Who Used VA Hospitals in 1986

	Patients Discharged During FY 1986	Patients Remaining as of September 30, 1986
Total	4,366	220
VA Region		
Northeast	224	12
Mid Atlantic	166	6
Southeast	73	8
Great Lakes	305	19
Midwest	2,116	110
West	458	31
Southwest	1,024	34
State of Residence		
South Dakota	1,060	40
Oklahoma	510	14
Montana	294	21
Arizona	255	15
California	216	16
New York	185	12
New Mexico	183	8
Wisconsin	167	9
Minnesota	165	6
North Dakota	149	15
Nebraska	149	3
Washington	138	6
North Carolina	117	3
All Other	778	52
Age		
Under 25 Years	30	0
25-34	510	20
35-44	963	62
45-54	772	36
55-64	1,218	48
65-74	718	46
75-84	129	8
85 and over	26	0
Period of Service*		
Spanish American War	0	0
World War I	18	0
World War II	1,550	74
Pre-Korean conflict	47	2
Korean conflict	790	41
Post-Korean conflict	330	15
Vietnam era	1,261	77
Post-Vietnam era	316	10
Other	54	1
Service-Connected Disability Status		
Service-connected	363	15
Service-connected, treated for nonservice-connected conditions	932	51
Nonservice-connected	3,020	153
Non-veteran	51	1

(continued on p. 4

* For veterans with multiple periods of service, the most recent period of service is reported.

(continued from p. 1)

	Patients Discharged During FY 1986	Patients Remaining as of September 30, 1986
Marital Status		
Divorced	1,220	66
Married	1,790	81
Never Married	736	44
Separated	219	11
Widowed	385	14
Unknown	46	4
Sex		
Male	4,268	217
Female	98	3
Attained Length of Stay		
30 days or less	3,728	155
31-60 days	473	23
61-90 days	64	12
91-365 days	85	17
366 days or more	16	15
Primary Diagnosis (total)	4,366	220
Total Psychoses	263	32
Psychoses other than drug or alcohol-related	188	22
Alcohol and drug-related psychoses	75	10
Total Other Psychiatric	1,045	37
Alcohol dependence/abuse	880	28
All other non-psychotic mental disorders, including drug dependence/abuse	165	9
Total Medical and Surgical	3,058	151
Heart diseases	379	9
Digestive diseases other than abdominal hernias or cirrhosis	263	16
Injuries and poisonings	233	6
Factors other than disease or injury affecting health status and resulting in contact with health services	438	48
Malignant neoplasms	186	8
Musculoskeletal system diseases	170	7
Symptoms, signs and ill-defined conditions	171	4
Circulatory system diseases other than heart diseases or cerebrovascular diseases	121	7
All other medical or surgical	1,087	46

To obtain copies of this report, contact Ms. Ruby McCrae, FTS 373-2315.

Inquiries about the substance of the report should be directed to the author:

Donald Stockford
Biometrics Division (712)
Statistical Policy and
Research Service
Telephone: (202) 233-2354

Office of Information Management
and Statistics
Veterans Administration
810 Vermont Avenue, NW
Washington, DC 20420

STATEMENT OF
MR. DAVID ORTEGA SHAW AND MR. RAYMOND C. FIELD
DEPARTMENT OF VETERANS AFFAIRS ADVISORY COMMITTEE
ON NATIVE AMERICAN VETERANS
BEFORE THE
SENATE SELECT COMMITTEE ON INDIAN AFFAIRS

November 14, 1989

American Indian Veterans receive less than their proportionate share of D.V.A. Guaranteed Home Loans. At present, American Indian Veterans cannot receive guaranteed home loans if they reside on reservation and trust lands. American Indians shouldn't be barred from these farm and home loans just because they live on reservation and trust lands. This unintentional, but very real discrimination exists because the Federal government holds this land in trust, and cannot transfer title as security for the loans to private lenders.

American Indian Veterans comprise 0.6% of all living veterans in civilian life but receive only 0.4% of guaranteed home loans. There is a critical shortage of housing for American Indian Veterans. Trust status of Indian lands includes reservations, individual allotments and tribal land. All three categories are trust property and are held in trust by the Federal government for the benefit of tribes or individuals. Land held in trust cannot be sold without the consent of the Federal government and the tribes. Trust lands include allotment trust land which is land held by the U.S. government in trust for an individual Indian or for two or more Indians holding individual interests in common and tribal trust land which is held in trust for a tribe. The rights of individual tribal members depends on treaties, agreements, and tribal law but usually the individual has no rights to ownership of any specific parcel of tribal property. Individuals may

have certain land use rights which includes occupying a particular tract of land plus grazing, fishing, and timber rights.

An issue that is frequently identified as interfering with the opportunities of a qualified Indian veteran seeking a home loan on reservation property is tribal communal ownership. Individual tribal members can never own their particular tract of reservation land nor can the land be sold to non-Indians. Land usage is usually based on agreements or leases. In so far as the D.V.A. and B.I.A. are concerned the issue of tribal ownership does not pose a problem. DVB Circular 26-65-16 dated May 27, 1965, Memorandum of Understanding between the Commissioner of Indian Affairs and the Administrator of Veterans Affairs waived the need for leases to be freely assignable and transferable with respect to applications from Indian veterans for V.A. guaranteed, insured, and direct loans for which leasehold interests in trusts or restricted land are used as security. Other conditions must be met including the length of the unexpired term of the lease, however, assignability of the leasehold interest is not a condition of acceptance. This memo of understanding probably had greater applicability during the period the V.A. offered direct home loans. The need for the D.V.A. and B.I.A. to enter into a memo of understanding to waive the need for "freely assignable" leases implies that there is difficulty in reassignment of leasehold interests.

Following the termination of the D.V.A. Direct Home Loan Program the lending institution became the principal component of the D.V.A. guaranteed home loan program. Lending institutions are reluctant to provide loans to qualified Indian veteran applicants:

A. Assignability/transferability of property or leasehold interests: reservation land is communally owned and cannot be deeded to individuals or corporations. Leasehold interests, if assignable, would have little security value to a lending institution. As referenced in 25 Code of Federal Regulations (CFR Ch. 1 (4-1-87 Edition) 162.12) leases, sub-leases, and assignments are reassignable:

"(d) with the consent of the Secretary, leases of tribal land to individual members of the tribe or to tribal housing authorities may contain provisions permitting the assignment of the lease without further consent or approval where a lending institution or an agency of the United States makes, insures or guarantees a loan to an individual member of the tribe or to a tribal housing authority for the purpose of providing funds for the construction of housing for Indians on leased premises; provided, the leasehold has been pledged as security for the loan and the lender has obtained the leasehold by consent of the Secretary also contain provisions permitting the lessee to assign the lease without further consent or approval."

B. V.A. Loan Guarantee Program:

Lending institutions tend to perceive Indian applicants as poor credit risks.

C. Resale: In the event of default by the Indian veteran, the lending institution could encounter difficulty accessing the reservation for repossession purposes and could have difficulty selling the property given the low demand for non-Hud housing on reservations.

Discussion:

Any modification of the V.A. Loan Guarantee Program would need to address the issue of re-assignability of property to lending institutions, the percent of the loan that is guaranteed by D.V.A., and the process of repossession and resale in the event of foreclosure. Since the tribes own the land, the issues of property assignability, repossession and resale would need to be negotiated with tribes on an individual tribal basis.

Marketability of Property: In entering into a loan arrangement with a qualified Indian veteran applicant the lending institution must determine if leasehold interests offer sufficient loan security and can be resold in the event of foreclosure. The marketability of reservation property is obviously more restricted than off reservation property; however, the demand for such properties would may vary greatly among tribes. Factors such as the size of the tribe, the geographic location of the tribe, the number of commercial enterprises on the reservation, and the number of B.I.A. and I.H.S. employees on or near the reservation, would need to be considered as determinants of marketability. How much of a demand is there for a particular piece of property within the reservation millieu? Marketability assessment would need to be specific to the property nd tribe in question.

Reestablishment of the D.V.A. Direct Home Loan Program would eliminate the need for the lending institution and would simplify the lending process. Policy discussions with B.I.A. and tribes regarding property assignability, repossession and resale would need to be negotiated.

The D.V.A., the individual tribes, and/or the B.I.A. would need to agree on how any losses created by defaulted loans would be absorbed or shared, for example:

(a) In the event a forfeiture of an Indian member's beneficial interest of a leasehold interest in allotment trust land, the appropriate department shall first offer it for sale to an Indian member having a beneficial interest in the land on which the default occurred, at a price equal to the unpaid balance of the contract price.

(b) In the event of a forfeiture, the appropriate department shall secondarily offer and/or give preference to any qualified Indian Veteran approved by the tribal government at a price equal to the unpaid balance of the contract price.

(c) In the event of a forfeiture, the appropriate department shall thirdly offer it for sale to the tribe for whom the land is held in trust at a price equal to the unpaid balance of the contract price. If the tribe fails to accept the offer, the department shall next offer it to the United State Secretary of the Interior at the same price.

Where all the parties to whom the department is required to offer the property under subdivision (a) or (b) the department shall give first preference to any good faith offer by a person approved by the tribal government on which the allotment land is sited.

Important Considerations

1. Definition of home sites on reservation trust land: Where more than on individual is given a home site, a survey of this area would need to be performed in a reasonable period of time, 45-60 days.

Discussion: Tribes and the Bureau of Indian Affairs (BIA) would need to priorities homesite surveys in order to expedite the processing of any type of loan programs for veterans. The cost of such surveys and the appropriate survey responsibility would need to be established prior a participation contract being engaged. Authority to grant a homesite to an eligible veteran by the Tribe or BIA would also have to be established in a reasonable time frame.

2. Reasonable access to homesite - an access to the homesite would have to be established. The Tribe and or BIA would need to be considered as the primary agent in this matter.

3. Sufficient income to support mortgage payment - a demonstrated income to support the mortgage payment would need to be demonstrated by the veteran and spouse prior to qualification for home loan benefits. The D.V.A. could and would consider various options to this area:

a. Modification of credit.

b. The growing of food on the property (potential) in lieu of cost factors associated with food purchases.

c. Raising of livestock in lieu of cost factors associated with food purchases.

d. Combining veteran and spouses incomes to support mortgage payments over a long period of time.

4. M.O.U. for 1965 according to D.V.A. is still in effect. A clarification or update from the B.I.A. as to this M.O.U. would be helpful.

5. Joint funding between native governments and federal government in which tribes have a stake in the management of a loan program or a variety of loan programs. A localized loan program overseen by a sound auditing program (C.P.A. under contract) and parameters for operation in order to assume continued funding will lend credibility to the program training would be provided to tribes by the D.V.A. inclusive of but not limited to appraising, property management, credit reporting etc.

Summary: The underutilization of the V.A. Loan Guarantee Program by qualified Indian veterans for guaranteed home loans on reservation land appears to be related to the following issues: assumed inability of the Indian applicant to obtain title to land on reservation, assumed difficulty in reassigning title to lending institution, assumed problems associated with accessing reservation in the event of forecloure, assumed lack of a market for non-HUD housing on reservations and possibly the insufficiency of the D.V.A. guarantee. Efforts to address the problems associated with the D.V.A. Loan Guarantee Program would require among other things, collaborative educational activity at local and area levels aimed primarily at the tribes and lending institutions. The tribes need to target specific lending institutions for the purpose of demonstrating the effectiveness of tribal foreclosure mechanisms and to offer information on the

marketability of the property in the event of default. Although many of the same issues would remain, the reimplementation of the D.V.A. Direct Home Loan Program would eliminate the need to include lending institutions in the educational process and would expedite the correction of the problem.

STATEMENT OF
DR. SAMUEL K. APUNA, JR.
SCHOOL OF PUBLIC HEALTH
UNIVERSITY OF HAWAII AT MANOA
BEFORE THE
SELECT COMMITTEE ON INDIAN AFFAIRS
OF THE
UNITED STATES SENATE
WASHINGTON, D. C.
November 14, 1989

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE,
Aloha from Sunny Hawaii:

Thank you for this privilege to discuss some of the problems confronting the Native Hawaiian veterans in Hawaii. I am Samuel 'Kamuela' Apuna serving on the faculty of the School of Public Health, University of Hawaii at Manoa. The views I will present today do not represent that of the School of Public Health at the University of Hawaii or any other organization. I speak as a concerned Native Hawaiian veteran, drawing from the experiences I gained during the eight years I served as the Director of Health and Human Services at the Office of Hawaiian Affairs, as a member of the Advisory Committee to Veterans Administration for Native American Veterans, from my twenty-eight (28) years of military service with the Hawaii National Guard and the U. S. Army and my present position with the University of Hawaii.

I would first like to thank the members of this committee who were instrumental in the establishment of the four Veterans Administration (VA) clinics in Hawaii and the one on Guam. For the first time many veterans who live on the neighboring Hawaiian Islands and are "gun-shy" of flying to the Oahu clinic now have access to uninterrupted medical and psychiatric services.

In speaking about the Native Hawaiian veteran, I will use the Federal interpretation of the term Native Hawaiian which is defined as a descendant of the aboriginal peoples who lived in Hawaii prior to 1778. No blood quantum distinction will be used.

As a preface to my presentation, let me say that there are no accurate information as to how many Native Hawaiian veterans there are in Hawaii. The Veterans administration includes Native Hawaiians within a broad classification titled "Asiatic Pacific Islanders" which also includes eight other major ethnic races such as Japanese, Chinese, Korean and other Pacific Islanders. No one has ever surveyed or identified the number of Native Hawaiian veterans in Hawaii. An important question which should be kept in mind during the presentation is, "How can strategic planning be developed to improve the standards of Native Hawaiian veterans when no one knows their

numbers, health status or Island location?" VA reportedly identifies Native Hawaiian veterans by ZIP codes. If only one action could result from Senate Bill 13, it should be a provision for the identification of the Native Hawaiian veterans and the authentication their health status.

In my presentation, I would first like to readdress the continuing problem of PTSD affecting the Native Hawaiian veteran with specific discussion about an emerging group of Viet Nam veterans who are now retiring from the ranks of the Hawaii National Guard and Reserve Units; second, the low utilization of V. A. services by Native Hawaiian veterans; thirdly, the high demand for Native American health-care professionals and finally the reauthorization of the Advisory Committee for Native American Veterans.

Concerning PTSD affecting the veterans from Hawaii and other Pacific Islands, this subject is appropriately covered by the final report of the Advisory Committee to VA on Native American Veterans and has been discussed in considerable depth by renown experts. Dr. Roger S. Hamada, at a Senate Committee hearing, on July 1988, expounded on the magnified effects of PTSD on the oriental and polynesian servicemen and women who fought in both Korea and Viet Nam. Because our skin tone and physical features were alike to that of the Koreans and the Viet Namese,

Native Hawaiians were at times mistaken for the enemy or even taunted by our fellow soldiers. Even though we, Native Hawaiians, wore the American fighting men's uniforms, at times it was difficult for us to identify ourselves as fellow Americans, to other unfamiliar American soldiers. Additionally, some of the veterans from Hawaii reported considerable distress caused by the internal conflict of our Asian cultural background and fighting in a war against Asians. This added stress compounded the effects of PTSD on the Native Hawaiian veterans, as well as other Native American veterans who exhibit similar physical characteristics.

I would like to discuss a yet more explosive problem affecting PTSD and the Native Hawaiian veteran. There is now emerging a group of Native Hawaiian veterans that are manifesting very serious social disorders. This group of Viet Nam veterans are Native Hawaiians currently retiring from the National Guard and the United States Reserve Forces in Hawaii. These Hawaiian veterans served their time in the Guard and Reserve with a combat tour in Viet Nam. They have completed their mandatory service time and are reaching eligibility for retirement. Members of this group have harbored suppressed emotions since returning from combat in Viet Nam. They suffered the same indignation as other servicemen from Hawaii but with an additional traumatic experience which compounded their post traumatic stress symptoms.

The Hawaii National Guardsmen and the members of the 100th Army Reserve Battalion all volunteered for units with the understanding that they would train together and, if activated, would fight together, as a unit. There was that strong comradery normally found in units where everyone knew each other intimately. Many worked together in civilian jobs or were related to each other. From their initial enlistment, they thought that they were a team and would enter combat as a team. In June of 1968, the 29th Hawaii National Guard Brigade was activated and joined by the 100th Battalion, a Reserve unit. They were sent to Schofield Barracks, Hawaii for training and immediately, thereafter, were infiltrated into Viet Nam as individual replacements. Because of the heavy casualties experienced by the Army units in Viet Nam, during the 1968 Tet offensive, it was imperative that individual replacements be expedited. The closest replacements to Viet Nam were in Hawaii and thus the Hawaii National Guard unit was stripped of its soldiers who were hurriedly shipped to Viet Nam as individual replacements.

The Native Hawaiian is customary a team player. They live and work in a "Ohana" or family concept. Their "family" can constitute blood relatives to an "extended family" of friends. They do not perform favorably as an individuals as compared to being a team member, which is his innate personality. This

traumatic displacement from a state of "family" comradeship and immediately supplanted into an alien American unit was magnified by this change of individual status happening during the most intensive fighting in Viet Nam. These soldiers did not experience the niceties of a smooth transition with a timely orientation. In some instances these Native Hawaiian citizen soldiers were flown into fire bases in the midst of a fire fight.

Individual cases of severe manifestation of PTSD are appearing from this group associated with an unusual high rate of divorces and antisocial disorders. These disorders are not limited to enlisted men as veteran senior officers are also exhibiting irrational antisocial behavior. The problem is that we only know of those notorious cases that are publicized by the news media or of those that are happening to individuals close to us. Many of the Native Hawaiian veterans in similar circumstances have not been identified nor are they seeking medical or psychiatry treatment. The dilemma of this situation is that we don't know the number, the magnitude of the problem nor the severity of the affects of this compounded PTSD on these Native Hawaiian veterans.

Senate Bill 13 provides for a study of PTSD effecting Native American veterans. This provision is needed and the funding

for the proposed PTSD studies of Native American veterans should remain intact. Further, VA should be instructed to ensure that a part of the PTSD study address this problem affecting the Native Hawaiian National Guard and Reservist veterans from Hawaii. We need to identify these affected Native Hawaiian veterans and introduce them to VA centers for needed help. Immediate outreach, executed with cultural sensitivity, by local practitioners, could positively identify and help these Native Hawaiian veterans critically affected by this compounded PTSD.

The second issue I wish to address is the low utilization of VA services by Native Hawaiians. Medical records at the VA clinic in Honolulu, indicates a very low percentage of Native Hawaiians utilize that facility. An example of VA services being under-utilized by the Native Hawaiian veterans is elaborated by an incident concerning homeless veterans. I wish I could present statistical data on the number of homeless Native Hawaiian veterans there are in Hawaii, but I cannot because no one in the State of Hawaii knows exactly how many there are, how they are surviving nor their health condition. We can assume that the figures are high, based on the numbers observed roaming the streets of Hawaii, living in homeless shelters and residing on the beaches and in the hills. An interesting anecdote told by Dr. Frank Chong, of the Waikiki

Health Center, is that the numbers of homeless living on the beach and on the streets in Waikiki is high enough to alarm the police as they usually clear the homeless from the beaches and streets of Waikiki the day before any major parade occurs in Waikiki.

In 1984, when beach people were evicted from living on a public beach in Maui, all of those evicted declared Hawaiian ethnicity and two-thirds of the male adults proclaimed themselves to be veterans. These beach people were all found qualified for welfare assistance yet none of the families had ever applied for any type of financial assistance. Most responded that they were uninformed of available assistance. This example supports the fact that the low utilization of VA and other governmental services by Native American veterans may be caused by the lack of information getting to them.

During a recent exchange of information between the representatives of American Indian, Alaskan Indian and the Native Hawaiian veterans, all agreed that there are some similarities between the Native Americans in their customs, traditions, character traits and use of traditional healing methods. One of these similar characteristics is the way we deal with services being offered by outsiders. All agreed that Native Americans are a proud people who will not beg or seek

assistance of any type from unfamiliar sources. Like other Native Americans, the Native Hawaiian is reluctant to visit the VA clinics or even other health facilities because of cultural differences.

The Veterans Administration, the Hawaii State Department of Health and other Servicing Agencies do operate health centers in Hawaii, however, the Native Hawaiian veterans are not receiving needed health services. The providers of these health services tend to be insensitive to the cultural differences of the Native Hawaiians. For example, VA established four heath and VA centers on the neighboring Islands staffed with technicians hired from the mainland. The basic complaint received from the Native Hawaiian veterans on those Islands was the staff's lack of knowledge of local culture and their insensitivity to Hawaiian custom. The service providers could not communicate with the Native Hawaiian veterans as theyspoke a different "language." Opening a clinic and hanging out their shingle does not constitute providing health care service to the Native Hawaiian veteran. The way the operators invite and attract Native Hawaiian veterans to the clinic comprises an important part of providing health service.

VA's use of the word "outreach" is a misnomer since the clinics

in Hawaii are inadequately staffed to provide proper outreach nor do they have personnel who know the community and culture of the Hawaiians and can reach the Native Hawaiian veterans. Outreach is a critical stage necessary to ensure that Native Hawaiian veterans avail themselves of VA facilities and obtain needed health services.

VA should not be singled out and solely criticized for the lack of local Hawaiian health practitioners. The problem lies in the lack of qualified educated Native Hawaiians in the health and social services field. While staffing the four new clinics, VA did advertise for the employment of local talent. Finding none, they had to expand their recruitment to the West Coast for the needed expertise. This difficulty will not be resolved in the foreseeable future as the education cycle takes time. Talented and potential Native Hawaiian students must be identified now and encouraged to enter into the different health professional careers. Especially with the upcoming Papa Ola Lokahi planning to establish nine health clinics in Hawaii, the competition for health professionals will be monumental. VA should consider developing and funding a program of upward mobility to educate local Native Americans who would eventually work in VA clinics.

As a point of clarification, the preceding statement about

health clinics whose staff lack sensitivity to the unique cultural difference of the Native Hawaiian veteran is not a common occurrence. There are health clinics in Hawaii that have hired and trained local talent to fit within their network and conduct outreach within the community. Of those are the Waianae Coast Comprehensive Health Center and the Kalihi-Palama Health Clinic.

The letter of invitation to appear here, stated that this Committee wished to receive the views of the Native American V. A. Advisory Committee on the extent of problems, level of services and the possible solutions in meeting the needs of Native American Indian Veterans. The final report of the Committee covers these topics very appropriate, therefore, those recommendations are not repeated. This recognition of the Native American Advisory Committee is gratifying, even though VA is not now using the committee for what it was originally created. There continues to be a need for this type of advisory committee which gathers "grass root" information.

In addition to the committee recommendations, I would like to summarize my presentation with these recommendations:

1. That continued emphasis on identifying the veterans who are affected by PTSD and providing them with proper services should be paramount above all other items on the VA's list of priorities. Within this priority the Native Hawaiian veterans should be a priority target group. This means surveying and identifying the Native Hawaiian veterans, by location (Island), authenticating their health status which would eventually provide them with needed medical and psychiatric services.

2. Developing a meaningful outreach program within the VA health system that is staffed with local professionals who are sensitive to the customs and traditions of the Native Americans they are servicing. This would include training Native Americans as outreach workers. #The Honolulu Veterans Center proved that by taking a Native Hawaiian non-professional, who is knowledgable about the customs and traditions of the Native Hawaiian veterans and training him to be an outreach worker achieved better results than hiring a professional who was not native to the Islands. This will work in all the Native American communities.

3. Promoting Native Hawaiian students into entering professional health fields with their #specialties focusing on addressing PTSD #affecting the Hawaiian veteran. This action should be accomplished as soon as possible so as to experience notable improvement in our health and counselling services to Native Hawaiians.

4. The reauthorization of the Advisory Committee to VA for Native American Veterans in essential towards the betterment of the conditions of Native American Veterans. The adage 'It takes one to know one' works very well with Native American Veterans. The Advisory Committee proved to be invaluable by the breadth and depth of their investigation of problems affecting Native American Veterans and their precise recommended solutions which were always sensitive to the values and traditions of the Native American veterans and their peoples.

University of Hawaii at Manoa

School of Public Health
1960 East-West Road • Honolulu, Hawaii 96822

December 15, 1989

Select Committee on Indian Affairs
Washington D.C. 20510-6450

Dear Sir;

Enclosed is the transcript of my testimony presented to your Committee on November 14, 1989. I find the contents of the transcript to be correct, with no changes.

Further, provided are my answers to the prepared questions furnished me at the hearing. The questions are not repeated and answers refer to the question by its numerical designation.

1. The Post Traumatic Stress Disorders affecting Native Hawaiian veterans and other Native American veterans are significantly much more complicated and serious than that of the typical American veteran. It was recognized by VA that the Black and women veterans were affected differently by their separate studies of the Blacks and the female veterans. However, the Native American veterans were ignored and included with the other American veterans when addressing PTSD support. VA has not recognized the different cultural and spiritual differences of the Native American veterans. VA studies has been conducted, in the past, with no sensitivity to these differences.

2. VA clinics are not sufficiently staffed nor are their present staff sufficiently knowledgeable to perform outreach within the Native American communities. Their insensitivity to the customs and traditions of the Native American restricts their ability to provide the services needed to help the Native American veterans. The immediate steps should be sensitivity training for their present staff, servicing the Native American communities, aggressive promotion of training and education of Native Americans to qualify them for staff positions in the VA clinics and the continued use of Native American practitioners to service Native American veterans.

3. The major obstacle restriction the recruitment and education of Native Americans from entering the health field are financial support and readjustment to the academic environment. VA or the Department of Education should provide exclusive scholarships for Native Americans who wish education in the health fields, which includes Social Work, Public Health, Medicine and Nursing. The Indian Health Service does provide a limited scholarship program,

however it is restricted to reservation Indians. There are no scholarship programs for other Native Americans. With regards to adjustment to the academic environment, there are some minor programs available at different universities and colleges with no national standardization. An educational opportunities program now available to Black students and faculty should be developed for Native American students and faculty, who wish to practice in their communities after graduation or teach and educate other Native American students.

4. The Native Hawaiian and Pacific Islands veterans have been neglected in the past by being ignored and overlooked. These natives are "low-keyed" who tend not to vocalize their plight or destitute life style. Therfore, no studies were conducted on the health conditions of these Native American veterans, in fact there is no data nor are there studies as to how many Native Hawaiian and Pacific Island veterans there are, their geographic location (by Island) nor their health status. This is the most important aspect of my testimony. We need to identify these veterans, from the general Asiatic Pacific Islanders racial identity. There geographic location must be establish to determine if proper medical and mental health services are properly distributed throughout the Islands of the Pacific. For strategic planning by VA, knowledge of their health conditions should be collected. The whole concept of servicing the Native American veteran in the Pacific is timing. The combat that these veterans experienced in WW II, Korea and Viet Nam has long passed and America has done nothing to identify them and their health conditions.

Respectfully, with much Aloha,

Samuel K. Apuna, Jr.

Mr. & Mrs. Ralph L. Eluska
5028 MILLS DRIVE • ANCHORAGE, ALASKA 99508

November [illegible] AM 9 3

Senator Daniel K. Inouye
United States Senate
Washington, D.C. 20510

Dear Senator Inouye,

I present this testimony to you regarding my father who is an American Indian Veteran of Foreign Wars. My father, Clement J. Goodluck Sr,. served in World War II in the European Theater. He was in the Quartermaster Corps. He left home before I was born and didn't return until I was almost three years old. I was born in March of 1943.

He never talked about the war. As children we asked him about his war experiences when the movie "What Did You Do In The War , Daddy?" came out but he never said anything. Mom said he didn't like to talk about it at all. He drank when I was growing up and I think that the haunting memories he had drove him to that.

He is still alive today and is 73 years old. He became a carpenter and worked also as a farmer, coal miner and bus driver throughout his life. He always has worked and even today he gets on his old tractor and tries to plow the land to ready it for growing crops in the arid New Mexico land on the Navajo Reservation. As he grows older those terrible memories of the war have returned and he has many nightmares. He is afraid to sleep at times because of those bad dreams.

My father still believes in the Navajo religion, our old Navajo way of life. Medicine men have been contacted a number of times and have been praying for him to try to dispel the nightmares. The V.A. hospitals cannot help him because they do not have the medicine men's help in which he believes.

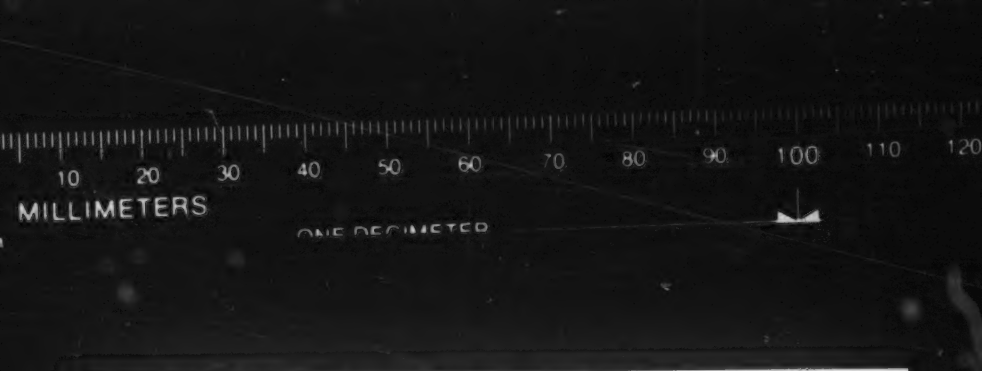
I believe our old Warriors should be taken care of using the medicine men they believe in just as the veterans who are in V.A. hospitals are cared for. If there was somewhere my father could petition to aid him in paying for the costs incurred in getting help from our Navajo medicine men, it would be a great help. We, his children, will help him as much as we can but I think the United States Government should also be helping him and others like him too.

Thank you for allowing me to present this testimony.

Sincerely yours,

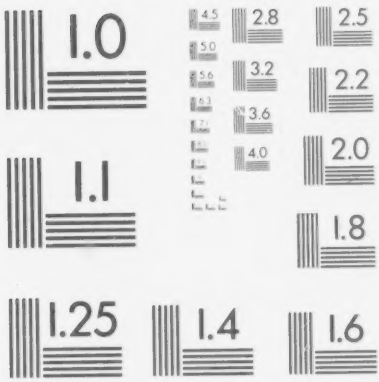
Sharon G Eluska

Sharon Goodluck Eluska



MICROCOPY RESOLUTION TEST CHART

(ANSI and ISO TEST CHART No. 2)



PHOTOGRAPHIC SCIENCES CORPORATION
770 BASKET ROAD
P.O. BOX 338
WEBSTER, NEW YORK 14580
(716) 265-1600

20:1

Compilation © 1990 Congressional Information Ser
All rights reserved.